ATTENTION:

PURSUANT TO THE FEDERAL FALSE CLAIMS ACT, THIS LETTER AND THE ENCLOSED COMPLAINT AND WRITTEN DISCLOSURE ARE SUBMITTED UNDER SEAL

May 4, 2020

U.S. District Clerk's Office *via: CM/ECF*
ATTN: Divisional Office Manager, Mr. Michael F. Oakes
655 E. Cesar E. Chavez Blvd., Room G65
San Antonio, Texas 78206

RE: **5:20-CV-00548**

The United States of America, ex rel. David Lyle Reynolds, Individually, and as Co-Independent Executor of the Estate of Thelma Watts Reynolds, and Susan Reynolds Veale, Individually, and in her capacity as Next Friend of the Estate of Thelma Watts Reynolds. v. Jayaseree Rao, M.D, Jayasree Rao, MDPA, and Oncology San Antonio Cancer Center Network

Dear Mr. Oakes:

Pursuant to the service requirments of 31 U.S.C. § 3730(b) and FED.R.CIV.P. 4(i), enclosed please find the following pleadings and papers:

1. A copy of the Federal False Claims Act *qui tam* complaint filed *in camera* and under seal in the above-captioned action; including

2. An Appendix contaning the writen disclosure of substantially all material information and evidence the relators posess in support of the action – all of which have been incoproated by refenecre as exhbits to the above-captioned complaint.

Please file complaint and the exhbits included in the complain'ys Appendix under seal and in camera.

Respectfully submitted,

Mickey Johnson

John "Mickey" Johnson

Enclosures: 1) Federal False Claims Act *qui tam* complaint and 2) an Appendix contaning the writen disclosure of substantially all material information and evidence the relators posess in support of the action.

Cc:	Mr. David Lyle Reynolds	via email: tamudave@att.net
	Mrs. Susan Veale Reynolds	via email: srveale123@gmail.com
	Mr. Jon Powell	via email: jon@jpowell-law.com
	Mr. Brant Mittler	via email: bsm@mittlerlaw.com

JS 44 (Rev. 09/19)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

See attached.

(b) County of Residence of First Listed Plaintiff _____
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

See attached.

DEFENDANTS

See attached.

County of Residence of First Listed Defendant _____
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☒ 1 U.S. Government Plaintiff
- ☐ 2 U.S. Government Defendant
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT	TORTS		FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
☐ 110 Insurance	PERSONAL INJURY	PERSONAL INJURY	☐ 625 Drug Related Seizure of Property 21 USC 881	☐ 422 Appeal 28 USC 158	☒ 375 False Claims Act
☐ 120 Marine	☐ 310 Airplane	☐ 365 Personal Injury - Product Liability	☐ 690 Other	☐ 423 Withdrawal 28 USC 157	☐ 376 Qui Tam (31 USC 3729(a))
☐ 130 Miller Act	☐ 315 Airplane Product Liability	☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability		PROPERTY RIGHTS	☐ 400 State Reapportionment
☐ 140 Negotiable Instrument	☐ 320 Assault, Libel & Slander	☐ 368 Asbestos Personal Injury Product Liability		☐ 820 Copyrights	☐ 410 Antitrust
☐ 150 Recovery of Overpayment & Enforcement of Judgment	☐ 330 Federal Employers' Liability	PERSONAL PROPERTY	LABOR	☐ 830 Patent	☐ 430 Banks and Banking
☐ 151 Medicare Act	☐ 340 Marine	☐ 370 Other Fraud	☐ 710 Fair Labor Standards Act	☐ 835 Patent - Abbreviated New Drug Application	☐ 450 Commerce
☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)	☐ 345 Marine Product Liability	☐ 371 Truth in Lending	☐ 720 Labor/Management Relations	☐ 840 Trademark	☐ 460 Deportation
☐ 153 Recovery of Overpayment of Veteran's Benefits	☐ 350 Motor Vehicle	☐ 380 Other Personal Property Damage	☐ 740 Railway Labor Act	SOCIAL SECURITY	☐ 470 Racketeer Influenced and Corrupt Organizations
☐ 160 Stockholders' Suits	☐ 355 Motor Vehicle Product Liability	☐ 385 Property Damage Product Liability	☐ 751 Family and Medical Leave Act	☐ 861 HIA (1395ff)	☐ 480 Consumer Credit (15 USC 1681 or 1692)
☐ 190 Other Contract	☐ 360 Other Personal Injury		☐ 790 Other Labor Litigation	☐ 862 Black Lung (923)	☐ 485 Telephone Consumer Protection Act
☐ 195 Contract Product Liability	☐ 362 Personal Injury - Medical Malpractice		☐ 791 Employee Retirement Income Security Act	☐ 863 DIWC/DIWW (405(g))	☐ 490 Cable/Sat TV
☐ 196 Franchise				☐ 864 SSID Title XVI	☐ 850 Securities/Commodities/ Exchange
				☐ 865 RSI (405(g))	☐ 890 Other Statutory Actions
REAL PROPERTY	CIVIL RIGHTS	PRISONER PETITIONS		FEDERAL TAX SUITS	☐ 891 Agricultural Acts
☐ 210 Land Condemnation	☐ 440 Other Civil Rights	Habeas Corpus:		☐ 870 Taxes (U.S. Plaintiff or Defendant)	☐ 893 Environmental Matters
☐ 220 Foreclosure	☐ 441 Voting	☐ 463 Alien Detainee		☐ 871 IRS—Third Party 26 USC 7609	☐ 895 Freedom of Information Act
☐ 230 Rent Lease & Ejectment	☐ 442 Employment	☐ 510 Motions to Vacate Sentence			☐ 896 Arbitration
☐ 240 Torts to Land	☐ 443 Housing/ Accommodations	☐ 530 General			☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
☐ 245 Tort Product Liability	☐ 445 Amer. w/Disabilities - Employment	☐ 535 Death Penalty	IMMIGRATION		☐ 950 Constitutionality of State Statutes
☐ 290 All Other Real Property	☐ 446 Amer. w/Disabilities - Other	Other:	☐ 462 Naturalization Application		
	☐ 448 Education	☐ 540 Mandamus & Other	☐ 465 Other Immigration Actions		
		☐ 550 Civil Rights			
		☐ 555 Prison Condition			
		☐ 560 Civil Detainee - Conditions of Confinement			

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
31 U.S. Code §?3729.False claims

Brief description of cause:
See attached

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:

JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) **Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) **County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) **Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. **Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. **Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. **Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. **Origin.** Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statue.

VI. **Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service

VII. **Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. **Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

CIVIL COVER SHEET ATTACHMENT

I. (a) Plaintiffs:

THE UNITED STATES OF AMERICA, ex rel. DAVID LYLE REYNOLDS, INDIVIDUALLY, AND AS CO-INDEPENDENT EXECUTOR OF THE ESTATE OF THELMA WATTS REYNOLDS, AND SUSAN REYNOLDS VEALE, INDIVIDUALLY, AND IN HER CAPACITY AS NEXT FRIEND OF THE ESTATE OF THELMA WATTS REYNOLDS.

Defendants:

JAYASREE RAO, M.D, JAYASREE RAO, MDPA, AND ONCOLOGY SAN ANTONIO CANCER CENTER NETWORK

I. (c) Attorneys *(Firm Name, Address and Telephone Number)*

THE POWELL LAW FIRM
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John "Mickey" Johnson
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LAW OFFICE OF BRANT S. MITTLER
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VI. CAUSE OF ACTION. Brief Description of Cause:

This is a mis-staging of cancer and subsequently prescribing chemotherapy based upon the mis-staging case – which results in Medicare being billed for improper chemotherapy treatments. From November 11, 2015 until the date of filing this complaint (hereinafter the "relevant period") Defendants failed to provide adequate care for cancer patients of Oncology San Antonio Cancer Center Network ("OSACCN" and Jayasree Rao, MDPA ("Dr. Rao MDPA"), resulting in egregious

harm and even death. In the process, Defendants have defrauded the United States and by seeking, and receiving, substantial reimbursement from the Medicare for care purportedly provided to these cancer patients, despite knowing that such "care" was deficient, inadequate, substandard, and did not promote the maintenance or enhancement of the quality of life for OSACCN and Dr. Rao MDPA patients.

During the relevant period, Defendants knowingly directed and approved of the billings by OSACCN and Dr. Rao MDPA to Medicare, and knowingly accepted and approved of the receipt by OSACCN and Dr. Rao MDPA of Medicare, despite knowing that the services provided to OSACCN and Dr. Rao MDPA patients were deficient, inadequate, substandard, and did not promote the maintenance or enhancement of the quality of life for OSACCN and Dr. Rao MDPA patients. During the relevant period, Defendants perpetrated a fraud on the United States by making material and objectively false representations in the submission of the Medicare claims. Defendants were unjustly enriched by the improper payments from Medicare. Defendants should be required to account for and disgorge their unlawful profits.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS SAN ANTONIO DIVISION

THE UNITED STATES OF AMERICA,	§	
ex rel. [UNDER SEAL],	§	
	§	
PLAINTIFFS,	§	
	§	
V.	§	**5:20-CV-00548**
	§	
[UNDER SEAL],	§	**FILED IN CAMERA AND**
	§	**UNDER SEAL**
	§	**31 U.S.C. §§ 3729-32**
DEFENDANTS.	§	**JURY TRIAL DEMANDED**

UNDER SEAL

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS SAN ANTONIO DIVISION

THE UNITED STATES OF AMERICA, ex rel. [UNDER SEAL],	§	
PLAINTIFFS,	§	
V.	§	**5:20-CV-00548**
[UNDER SEAL],	§	**FILED IN CAMERA AND UNDER SEAL 31 U.S.C. §§ 3729-32**
DEFENDANTS.	§	**JURY TRIAL DEMANDED**

PLAINTIFFS' FALSE CLAIMS ACT COMPLAINT "QUI TAM"

THE POWELL LAW FIRM

By:/S/ John "Mickey" Johnson
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Texas State Bar No. 24094002

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Email: bsm@mittlerlaw.com
Counsel for Relators

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS SAN ANTONIO DIVISION

THE UNITED STATES OF AMERICA, ex rel. DAVID LYLE REYNOLDS, INDIVIDUALLY, AND AS THE CO-INDEPENDENT EXECUTOR OF THE ESTATE OF THELMA WATTS REYNOLDS, AND SUSAN REYNOLDS VEALE, INDIVIDUALLY, AND IN HER CAPACITY AS NEXT FRIEND OF THE ESTATE OF THELMA WATTS REYNOLDS,	§	
PLAINTIFFS,	§	
V.	§	**5:20-CV-00548**
JAYASREE RAO, M.D, JAYASREE RAO, MDPA, AND ONCOLOGY SAN ANTONIO CANCER CENTER NETWORK,	§	**FILED IN CAMERA AND UNDER SEAL 31 U.S.C. §§ 3729-32 JURY TRIAL DEMANDED**
DEFENDANTS.	§	

FALSE CLAIMS ACT COMPLAINT "QUI TAM"

I. INTRODUCTION

TO THE HONORABLE JUDGE OF SAID COURT:

David Lyle Reynolds, Individually, and as the Co-Independent Executor of the Estate of Thelma Watts Reynolds ("Mr. Reynolds"), and Susan Reynolds Veale, Individually, and in her capacity as Next Friend of the Estate of Thelma Watts Reynolds ("Mrs. Veale") (collectively referred to hereinafter as "Relators") file this action under 31 U.S.C. §§ 3729-32 (the "False Claims Act") on behalf of The United States of America ("USA"), to recover from Jayasree Rao, M.D. ("Dr. Rao"), Jayasree Rao, MDPA ("Dr. Rao MDPA") and Oncology San Antonio Cancer Center Network ("OSACCN) (collectively referred to hereinafter as ("Defendants") for all damages, penalties and other remedies

available under the False Claims Act on behalf of the United States and themselves and would show unto the Court the following:

II. PARTIES

1. Relator, David Lyle Reynolds, individually, and in his capacity as the Co-Independent Executor of the Estate of Thelma Watts Reynold ("Mr. Reynolds"), is an individual and citizen of the United States of America residing in Bedford, Texas.

2. Relator Susan Reynolds Veale, individually, and in her capacity as Next Fried of the Estate of Thelma Watts Reynolds ("Mrs. Veale"), is an individual and citizen of the United States of America residing in San Antonio, Texas.

3. Jayasree Rao, M.D. ("Dr. Rao") is an oncologist who practices at the Oncology San Antonio Cancer Center Network located at 19288 Stone Oak Parkway, Suite B, San Antonio, TX 78258.

4. Oncology San Antonio Cancer Center Network ("OSACCN") is an oncology practice group with its principle address at 19288 Stone Oak Parkway, Suite B, San Antonio, TX 78258.

5. Jayasree Rao, MDPA ("Dr. Rao MDPA") is a professional association owned and operated by Jayasree Rao, M.D. with its principle address at 19288 Stone Oak Parkway, Suite B, San Antonio, TX 78258.

III. JURISDICTION AND VENUE

6. This Court maintains subject matter jurisdiction over this action pursuant to 31 U.S.C. §3732(a) (False Claims Act) and 28 U.S.C. § 1331 (Federal Question).

7. Venue is proper in this Court under 31 U.S.C. § 3732(a) because Defendants provide and offer professional medical services in the Western District of Texas.

8. Relators are the original source of and have direct and independent knowledge off all publicly

disclosed information that the allegations herein are based upon. Relators have personally gathered all the documentation substantiating the allegations herein. Additionally, Relators have voluntarily provided all such information to the Government prior to the filing of this action.

IV. INCORPORATION OF EXHBITS

9. Pursuant to Rule 10(c) of the Federal Rules of Civil Procedure, Relators file this Statement of Intent to Adopt by Reference Exhibits as part of this Complaint for all proposes and in support thereof, and hereby notify all Defendants herein that Relators intend to rely upon each and every factual and substantive statement and assertion contained in the exhibits set forth below and to use portions or all of the following documents in the exhibits set forth below. The exhibits labeled and named below are submitted herewith as Complaint exhibits herein:

Exhibit A.	Expert Report of Dr. Stephen Cohen dated November 26, 2018 and Dr. Cohen's CV.
Exhibit B.	Thelma Watts Reynold's deposition transcript dated March 15, 2019.
Exhibit C.	Lyle Reynold's deposition transcript dated August 19, 2019.
Exhibit D.	National Comprehensive Cancer Network Quick Guide article titled "Non-Small Cell Lung Cancer."
Exhibit E.	Jayasree Rao, M.D.'s deposition transcript dated December 18, 2019.
Exhibit F.	Texas Tribune article titled "Medicare Data Shines Light on Billions Paid to Texas Doctors."
Exhibit G.	San Antonio Express-News article titled "Two S.A. doctors are on list of top Medicare payments – Correction Appended."
Exhibit H.	San Antonio Express-News article titled "More Troubles at S.A. Oncology Practice."

Exhibit I. San Antonio Express-News Article titled "Oncologists allege paperwork was forged."

V. SUMMARY OF COMPLAINT

10. This is a mis-staging of cancer and subsequently prescribing chemotherapy based upon the mis-staging case – which results in Medicare being billed for improper chemotherapy treatments. From November 11, 2015 until the date of filing this complaint (hereinafter the "relevant period") Defendants failed to provide adequate care for cancer patients of OSACCN and Dr. Rao MDPA, resulting in egregious harm and even death. In the process, Defendants have defrauded the United States and by seeking, and receiving, substantial reimbursement from the Medicare for care purportedly provided to these cancer patients, despite knowing that such "care" was deficient, inadequate, substandard, and did not promote the maintenance or enhancement of the quality of life for OSACCN and Dr. Rao MDPA patients.

11. During the relevant period, Defendants knowingly directed and approved of the billings by OSACCN and Dr. Rao MDPA to Medicare, and knowingly accepted and approved of the receipt by OSACCN and Dr. Rao MDPA of Medicare, despite knowing that the services provided to OSACCN and Dr. Rao MDPA patients were deficient, inadequate, substandard, and did not promote the maintenance or enhancement of the quality of life for OSACCN and Dr. Rao MDPA patients. During the relevant period, Defendants perpetrated a fraud on the United States by making material and objectively false representations in the submission of the Medicare claims. Defendants were unjustly enriched by the improper payments from Medicare. Defendants should be required to account for and disgorge their unlawful profits.

12. Relators have filed a medical malpractice lawsuit against Defendants in Cause No. 2018CI13942

in the 45h Judicial District Court, Bexar County, Texas. Through this litigation, Relators have discovered a considerable amount of information which leads them to believe Defendants have engaged in a scheme to submit unreasonable and unnecessary cancer treatment and drug bills to Medicare for reimbursement. Relators are attaching and incorporating by reference some of the discovery information they have uncovered to support their allegations.

VI. MEDICARE REIMBURSEMENT

13. Through Medicare, the United States pays for certain medical care for cancer patients. During the relevant period, the Center for Medicare and Medicaid Services ("CMS") administered the Medicare program. In administering the Medicare program, CMS retains private insurance companies to act as fiscal intermediaries or agents of CMS and, pursuant to written agreements, make payments on behalf of the program's beneficiaries.

14. Upon information and belief, various fiscal intermediaries processed claims that were submitted by Defendants for medical care purportedly provided by Dr. Rao, Dr. Rao MDPA and OSACCN.

15. Statutes and regulations governing the Medicare program require health care providers to maintain – as a prerequisite to receiving payment under the programs – substantial compliance with all the pertinent rules and regulations governing the programs. Amongst other things, health care providers must assure that all services for which they submit claims for Medicare payment are "of a quality which meets professionally recognized standards of health care." 42 U.S.C. § 1320c-5(A)(2).

VII. FACTS

16. The facts outlined below have been verified by Relator's Expert Witness in the underlying medical malpractice lawsuit. A true and correct copy of the Expert Report of Dr. Stephen Cohen dated

November 26, 2018 and Dr. Cohen's CV is attached hereto and incorporated by reference as if set forth in full herein as Exhibit "A".

17. Thelma Watts Reynolds ("Mrs. Reynolds") was a cancer patient of Dr. Rao, Dr. Rao MDPA and OSACCN. Mrs. Reynolds was 81 years old when hospitalized with diverticulitis in 4/2015. The records of Dr. Jayasree Rao state 04/15/15 x-ray showed pneumonia in right upper lobe. The Chest CT was completed on 04/27/2015. A CXR 7/29/15 did show a right upper infiltrate with consolidation. Subsequent follow up of the lung changes included a negative bronchoscopy, and a PET/CT scan 7/8/15, and 10/02/2015 showed left upper lung lobe opacities. This PET/CT scan comparison 7/8/15 to 10/2/15 showed no significant changes. I did find the 10/02/15 PET/CT showed a 5.7x2.3 cm mass-like posterior upper lobe lesion bordering the fissure. The lesion's SUV was 9,4. In addition the scan showed a more caudal stable left upper lobe lesion of 2.7 x2.8 cm with a SUV 5.6. The hypermetabolic lesions suggest malignancy, along with infectious and inflammatory disease. The right upper lobe showed a 1.7 cm pleuronodular opacity with SUV 1.6 suggesting infectious/infiltrative disease.

18. Mrs. Reynolds had a thoracic PET/CT scan on 04/27/2015 which I noted above. I am concluding the 4/27/15, 7/8/15, 10/02/17 chest PET/CT scans showed no significant changes. They showed extensive bilateral upper lobe lesions and basilar multilobular atelectasis and fibrosis as well.

19. Mrs. Reynolds had a lung biopsy of the left upper lobe of lung on 11/16/2015. Six weeks after her most recent PET/CT chest scan, the biopsy revealed an adenocarcinoma. Mrs. Reynold's doctors at that time was Dr. Hector L. Gomez, and Dr. Christopher Joseph Muniz. The left upper lobe core biopsy revealed an adenocarcinoma, consistent with a lung primary. The biopsy was read by Dr. Nancy B. Banks a pathologist at Baptist Medical Center, San Antonio, Texas. The surgical pathology report revealed Dr. Banks discussed the diagnosis with Dr. Hector Gomez on 11/17//2015. Dr. Banks also

reported the atypical cell findings to Dr. Christopher Muniz on 10/16/17.

20. The report also noted that testing for critical molecular targeting, the ALK and EGFR markers, was to be done. An addendum to the pathology report dated 11/23/2015 showed the ALK gene rearrangement was detected in 37% of cells, and the EGFR test was not done due to inadequate tumor tissue. Importantly, the results of the ALK and EGFR testing were not in Dr. Rao's medical records and those two biomarkers were never referred to in any of Dr. Rao's treatment records of Mrs. Reynolds.

21. At the time of the diagnosis of her lung cancer Mrs. Reynolds was in reasonably good health. She was recently retired but was active and ambulatory. She had a history of diverticulitis, with the last episode 4/15/2015, about seven months before receiving the diagnosis of adenocarcinoma of the lung and receiving Avastin therapy. She had hyperlipidemia and was on antilipid meds. She also had controlled BP with antihypertensive drugs. In addition, she was medicated for anxiety and depression.

22. Dr. Rao provided an oncology consultation on 11/20/15. Her consultation on Mrs. Reynolds revealed she was asymptomatic at the time of diagnosis of adenocarcinoma of the lung. Her review of systems was negative as related to her neoplasm. Dr. Rao stated she reviewed the laboratory and diagnostic studies. Except for stating she had adenocarcinoma she cited no lab results and no other pathology. She does not discuss any PET/CT scan findings but concludes she suspected Stage IV disease radiographically. She did not mention any specific evidence, image-wise, that would support that stage of disease.

23. Dr. Rao told Mrs. Reynolds and her family that she had advanced stage disease and that her goal was to palliate and control her disease process. She indicated the goals of treatment were to prolong her life and to provide quality of life.

24. Dr. Rao started Mrs. Reynolds on Avastin and Carboplatin therapy on 11/27/2015.

25. She indicated that Mrs. Reynolds had several treatment options, but only considered chemotherapy/angiogenesis inhibitor treatment. She did not consider Taxol given her age. Dr. Rao did not mention the possibilities of surgery, radiation therapy, targeted therapy or even observation as reasonable alternatives.

26. She did note that Bevacizumab (Avastin) was associated with the risks of hypertension and bowel perforation, and informed Mrs. Reynolds and her family of these complications.

27. Dr. Rao made arrangements for Mrs. Reynolds to get an intravenous catheter placement for the administration of drugs.

28. In less than 1 month after starting Carboplatin and Avastin, Mrs. Reynolds was having gastrointestinal symptoms requiring cessation/delay of her treatment for toxicity.

29. Dr. Rao's 12/23/15 note points out Mrs. Reynolds is not a surgical candidate and was given Avastin/Taxol. Neither of these were true. Mrs. Reynolds was a surgical candidate and the medical records should have reflected that she received Avastin and carboplatin.

30. Dr. Rao's initial note in her office suggested stage IV disease.

31. It was known to Dr. Rao that her N and M clinical staging were 0 based on a number of negative PET/CT thorax and body scans. There are no extra thoracic or nodal metastases identified on her scans. Based upon information and belief, Mrs. Reynolds' initial T Stage was T3. She should have been Staged IIB. Dr. Rao's suggestion that Mrs. Reynolds had stage IV disease was not demonstrated by any imaging testing, and she made no notation of these test results to corroborate her conclusion about disease stage.

32. Classically T, N, & M The classic staging of lung cancer staging is done by the following criteria (T = Tumor, N=Nodes, M=metastasis):

- Stage IA-T1N0M0
- Stage IB-T2N0M0
- Stage IIA-T1N1M0
- Stage IIB-T2N1M0, T3N0M0
- Stage IIIA-T3N1M0, T1-T3N2M0
- Stage IIIB-T4 Any NM Any T N3M0
- Stage IV-Any T Any N M1
- TX-positive cancer cells without primary tumor on imaging or bronchoscopy T0-No evidence of primary tumor T is-carcinoma-in-situ T1-Tumor≤ 3 cm, surrounded by lung or visceral pleura, without bronchoscopic evidence of invasion more proximal than the lobar bronchus.
- T1a:≤2cm
- T1b:>2cm but≤3cm
- T2-Tumor with any of the following features: > 3 cm in greatest dimension, involves mainstem bronchus, ≥2 cm distal to the carina, invades the visceral pleura, associated with atelectasis or obstructive pneumonitis that extends to the hilar region but does not involve the entire lung T2a:>3cm but≤5cm
- T2b: >5cmbut≤7cm, Or tumors≤ 7 cm with invasion of visceral pleura, atelectasis of less than entire lung, proximal extent at least 2 cm from carina T3-Tumor of any size that invades any of the following: chest wall (including superior sulcus tumors), diaphragm, mediastinal pleura, parietal pericardium: or tumor in the main bronchus < 2 cm distal to the carina, but without involvement of the carina; or associated atelectasis or obstructive pneumonitis of the entire lung
- T3- tumors> 7 cm or with: Direct invasion of chest wall, diaphragm, phrenic nerve, mediastinal pleura, parietal pericardium, main bronchus< 2 cm from carina (without involvement of carina) and tumor nodules in the same lobe as the primary tumor.
- **T3 -tumors associated with additional tumor nodules (ATNs) in the same lobe as the primary tumor**
- T4 –Tumor of any size that invades any of the following: mediastinum, heart, great vessels, trachea, esophagus, vertebral body, carina: or tumor with a malignant pleural or pericardial effusion, metastatic tumor nodules in different lobe from the primary tumor.
- NX-Regional lymph nodes cannot be assessed N0-No regional lymph node metastases

N1-Metastasis to ipsilateral peribronchial and/or ipsilateral hilar lymph nodes, and involvement of intrapulmonary nodes by direct extension of the primary tumor.

- N2-Metastasis to ipsilateral mediastinal and/ or subcarinal lymph node(s).
- N3-Metastasis to contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene, or supraclavicular lymph node(s).
- MX-Presence of distant metastasis cannot be assessed.
- M0-No distant metastasis
- M1-Distant metastasis present including metastatic tumor nodules in the ipsilateral nonprimary tumor lobes of the lung.
- M1a: malignant pleural or pericardial effusion, pleural nodules or nodules in contralateral lung
- M1b: distant metastases

33. One of its aims is to determine which patients are resectable or not. Determines extent of disease and stratifies patients into therapeutic and prognostic groups.

34. Dr. Rao's pretreatment evaluations should have included Mrs. Reynolds' history, physical exam, and pertinent radiographic images, the lung biopsy pathology results and the results of the ALK rearrangement test and the EFGR assay done on the tumor. The fact that she did not get the ALK results is clearly a failure in the standard of care. Furthermore, this information never appeared in any of Dr. Rao's medical records of Mrs. Reynolds, which is also below the standard of care, at every subsequent visit.

35. Shortly after Mrs. Reynold's treatment started, she had gastrointestinal symptoms and a suspicion of bowel perforation. The Avastin was eliminated from subsequent treatment, as it was suspected to be the cause of her bowel perforation. Interestingly, many progress notes say she was started on palliative treatment with carboplatinum and Avastin and tolerated it well.

36. Mrs. Reynolds was started on treatment with Carboplatinum and Avastin on 11/27/15, and the

12/23/15 note says she was quite ill with gastrointestinal complaints. Getting drastically ill within 1 month of initiation of therapy can hardly be reconciled with "it was tolerated well". This inconsistency of the progress notes and the reality of the clinical situation was a common finding in the medical record, and will be addressed further. Dr. Rao's use of the term "palliative care" does not apply to a patient who is Stage II B who is more likely than not curable.

37. Mrs. Reynolds was switched to a combination of Cisplatinum and Alimta. Mrs. Reynolds' carboplatin therapy was discontinued because of an allergic reaction. Unfortunately, this fact was never presented in the cut and paste present illness notes. Cisplatinum is significantly more toxic than carboplatin, particularly for neuropathy. This omission from the present illness record is significant. In fact, the Cisplatinum was the cause of Mrs. Reynolds debilitating neuropathy.

38. Mrs. Reynolds remained on Cisplatinum/Alimta for quite a while, about 1 year. Because of neutropenia, nausea, fatigue, anemia, mucositis, weakness and weight loss the treatment schedule for Cisplatinum was changed to a weekly regimen.

39. According to Dr. Rao, Mrs. Reynolds lung cancer was Stage IV.

40. This is in error, as there was never evidence of metastatic disease outside of the left upper lobe of the lung. This misinterpretation of the facts by Dr. Rao fails the standard of care. The record repeatedly states she has metastatic and unresectable disease, not confirmed by the facts. This is a major medical error and is both negligence and gross negligence.

41. On 10/21/16 it is noted for the first time Mrs. Reynolds had uncontrolled hypertension due to Avastin. Yet, Avastin was stopped about 11 months previous.

42. The cut and paste review of systems and physical examinations repeatedly reflect no neurological symptoms or findings, until 12/9/16. At that time, bilateral lower extremity weakness and

an unsteady gait was noted. Dr. Rao indicated the presence of grade 0-1 peripheral neuropathy. On the same date, hypomagnesia, another side effect of Cisplatinum was reported.

43. On 12/30/16, three weeks after noting the presence of a peripheral neuropathy, Dr. Rao states there was no peripheral neuropathy present, but unsteady gait was present.

44. Mrs. Reynolds' unsteady gait was related to Cisplatinum induced motor neuropathy. There was no evidence that that Mrs. Reynolds had paresthesias. It is clear her neuropathy was primarily motor and underrecognized by Dr. Rao and her medical/nursing staff. The delayed recognition of her neuropathy contributed to her prolonged exposure to Cisplatinum. As a result, she developed severe, life altering, permanent peripheral neuropathy of hands and legs.

45. It should also be noted that, on several visits Mrs. Reynolds was seen by Physicians Assistants with oversight by Dr. Rao.

46. On 1/10/17 no coordination abnormalities or motor deficits were noted but unsteady gait persisted. Because of fatigue and weakness, switching therapy to Opdivo was considered.

47. Mrs. Reynolds was switched to Opdivo on 1/20/17 due to declining performance status from Cisplatinum/Alimta, and suspected progression of disease.

48. On 3/17/17 the progress note revealed unsteady gait, use of a walker and peripheral neuropathy of her hands. Gabapentin was initiated at a homeopathic dose. A similar note exists for 5/5/17.

49. Mrs. Reynolds experienced significant toxicities from her chemotherapy/Avastin regimens including: bowel perforation, hypertension, mucositis, anemia, thrombocytopenia, neutropenia, hyponatremia, hypomagmesemia, fatigue, weakness, weight loss and severe peripheral neuropathy.

50. Mrs. Reynolds was diagnosed with a left upper lobe adenocarcinoma on 11/16/15. Interestingly, a chest X-ray ordered by Dr. Hector Gomez on 7/29/15 indicated a right upper lobe infiltrate suggesting

pneumonia. An aspirational biopsy of the right upper lobe was done on 7/8/15 at Southwest General hospital with negative cytology for cancer and a negative bacterial culture. No mention of a left upper lobe lesion(s) was noted. This suggests the left upper lobe findings were not identifiable by chest X-ray.

51. On 04/27/2015 Mrs. Reynolds had a PET/CT. That study was essential in evaluating and staging her cancer for Mrs. Reynolds appropriate medical management. Extracting from reviewing the available imaging reports: 7/18/17, 10/2/15, 4/29/16, 8/16/16, 12/12/16, 5/26/17 PET/CT scans were done.

52. The results of these scans showed mostly stable disease, with decreased masses and hypermetabolism on 4/29/16. None of the reports from Dr. Rao's notes measure an objective response on these scans. By RECIST measurable criteria (categorizes quantitative tumor size changes into complete response, partial response, stable disease, or progressive disease) no significant PET/CT scan changes were found among the scan reports. More importantly, no imaging study ever showed progression to Stage IV metastatic disease.

53. Mrs. Reynold's records noted Mrs. Reynolds was taking Evista, but never indicated why. Dr. Rao's omission of information about a hormonal drug primarily used for breast cancer fails the standard of care.

54. In summary, Mrs. Reynolds had Stage IIB disease. Dr. Rao mis-staged her disease 11/16/2015 as Stage IV and on all subsequent visits. Mrs. Reynolds cancer was resectable and curable at that time, with surgery-left upper lobectomy. Mrs. Reynolds was asymptomatic from her cancer on 11/15/15. Mrs. Reynolds had stable findings from 4/27/2015 to 10/2/15 on PET/CT scans. The appropriate management choices for an asymptomatic 81-year-old patient with confined low-grade adenocarcinoma, such as Mrs. Reynolds, would be left upper lobectomy, possible radiation, possible ALK kinase inhibitor, or observation.

55. Dr. Rao's incorrect diagnosis of Mrs. Reynolds' cancer stage caused Mrs. Reynolds to lose the chance for cure. This is a significant failure in the standard of care. The toxicities endured by Mrs. Reynolds, have made employing curative therapy impossible.

56. Mrs. Reynolds had an ALK positive lesion. The significance of ALK gene is indicated by the fact the pathologist performed this test as part of the routine study of a lung cancer. If Mrs. Reynolds was staged IV by Dr. Rao, an ALK kinase inhibitor, Crizotinib should have been the treatment of choice. (Solomon BJ et al, NEJM 2014).

57. Dr. Rao should have known that targeted therapy with Crizotinib was the treatment of choice in Stage IV adenocarcinoma of the lung in patients with ALK positive disease. Not having this knowledge and not employing this therapy failed the standard of care.

58. Crizotinib is much less toxic and more efficacious than chemotherapy for ALK positive lung cancers. Failure to use Crizotinib, and using the other inappropriate neurotoxic agents noted above, is the direct and proximate cause of Mrs. Reynolds permanent and disabling neuropathy.

59. Failing to consider an ALK kinase inhibitor is below the standard of care and is negligent and grossly negligent. Remarkably, Dr. Rao failed to get the ALK results. This failed the standard of care. Dr. Rao made no inquiry and/or ignored the ALK results which is below the standard of care, both negligent and grossly negligent and a direct and proximate cause of Dr. Rao's use of inappropriate chemotherapeutic agents which caused permanent disabling neuropathy.

60. This failure and the failure to appropriately stage Mrs. Reynolds cancer led to the inappropriate administration of toxic chemotherapy.

61. The toxic chemotherapy of Cisplatinum/Alimta caused Mrs. Reynolds marked clinical deterioration, with severe peripheral neuropathy, which has been permanent and disabling.

62. Dr. Rao also failed to search out the results of Mrs. Reynold's EGFR result. There are several tyrosine kinase oral inhibitors that would be preferable if this test was positive.

63. Dr. Rao also failed the standard of care by administering Avastin to a patient with recent diverticular disease that required hospitalization. This resulted in a perforated bowel which was directly caused by the Avastin.

64. Bowel disease is a relative contraindication to the use of bevacizumab as it leads to a significant risk of bowel perforation, which Mrs. Reynolds experienced. A prudent approach by an oncologist should have been to avoid the risks of bowel perforation in a patient with symptomatic bowel disease, given its small chance of benefit. The risk of bowel perforation is so significant in a patient like Mrs. Reynold with a history of diverticulitis disease that is should preclude its usage.

65. Mrs. Reynolds had Stage IIB adenocarcinoma of the lung. The lesion was curable at the time of diagnosis. The upstaging/ wrong staging to Stage IV by Dr. Rao failed the standard of care by confusing probable lepidic spread as metastatic disease. This error caused Dr. Rao to give Mrs. Reynolds toxic palliative chemotherapy instead of employing curative treatment. She incorrectly labeled Mrs. Reynolds' disease non resectable and noncurative.

66. Dr. Rao did not seek the ALK results which were readily available, and should have been the basis for targeted therapy with Crizotinib. Crizotinib would have been the standard therapy in the setting of lung adenocarcinoma in an 81-year-old. She therefore failed the standard of care in not seeking this information, which is a causative reason for her error in administering therapy that caused a bowel perforation, numerous side effects outlined above, and life altering permanent peripheral neuropathy. Failing to consider and use Crizotinib was a failure in the standard of care.

67. Finally, upon information and belief, Mrs. Reynolds had bronchoalveolar adenocarcinoma. This

type of cancer is TTF1 and CK7 positive, as was Mrs. Reynold's tumor. Furthermore, this type of lesion is slow growing, susceptible to lepidic growth and limited aggressivity. This tumor would explain the local tumor involvement, absence of extrathoracic metastases, lack of significant measurable response to chemotherapy, and minimal, if any progression of tumor. Dr. Rao failed the standard of care by not seeking the pathological results of a positive ALK, TTF1 and CK7 marker.

68. Molecular testing is mandatory and is the standard of care in every lung cancer biopsy specimen obtained. Molecular testing is required in all stage IV patients with adenocarcinoma of the lung (Standardofcare.com) to avoid chemotherapy toxicity, and to choose the most efficacious therapy.

69. The Lung Cancer Mutation Consortium in the United States demonstrated that the median survival of patients without driver mutations, with drivers mutations but not treated with targeted therapy, and with driver mutations and treated with targeted therapy was 2.08 years, 2.38 years, and 3.49 years, respectively in patients with Stage IV disease. This suggests that if Mrs. Reynolds was treated appropriately with Crizotinib (even with inappropriately diagnosed Stage IV disease) she would survived many years with minimal toxicity. In fact, Mrs. Reynolds endured terrible non-curable debilitating neuropathy in the months prior to her death which is a direct result of Dr. Rao's mistreating and mis-staging and inappropriately treating her tumor. For illustrative purposes the following deposition testimony from Mrs. Reynold's indicates the severity of her debilitation as a result of her neuropathy:

Reynolds, Thelma, (Pages 18:22 to 20:9)

Q. Before we talk about that, do you know what your diagnosis is for your hands and your feet, the problems in your hands and feet? A. Well, it's chemothe- -- It's the chemotherapy that caused it. Q. Right. And are you aware that you've been diagnosed with peripheral neuropathy in -- A. Yes. Q.

-- your hands and feet? A. And I didn't know what that was. Q. Okay. Well, what -- Now do you know what peripheral neuropathy is? A. Yes. Q. And te- -- A. I can't use my hands, and I can't walk right. Q. All right. Well, tell the jury how your hands feel. A. Well, they're tingly and they're like paralyzed. Q. And tell the jury how your feet feel. A. Well, they have minds of their own. Q. Okay. A. I have no control over them at times. Q. Now, on some of your medical records it mentions something called "foot drop", that your foot was not staying in a normal position. Tell the jury how the neuropathy affected your ability to walk. A. Well, they say I have a rolling ankle on my right foot. And when I try to stand up, my right foot just gives way and I can't stand up. Q. All right. So, are you able to walk now without the help of a walker or a -- A. No. Q. No. Are you able to walk with the help of a walker? A. No. Q. So, are you now wheelchair-bound? A. Yes.

70. A true and correct copy of Thelma Watts Reynold's deposition transcript dated March 15, 2019. is attached hereto and incorporated by reference as if set forth in full herein as Exhibit "B".

71. The following deposition testimony from Mrs. Reynold's husband, Lyle Reynolds, is also illustrative of the severity of the debilitations caused by Mrs. Reynold's neuropathy:

Reynolds, Lyle, (Pages 5:21 to 6:25)

Q. Okay. Can you explain to the jury how your wife was affected by the neuropathy. What did it do to her hands? MR. WOOLSEY: Objection; form. THE WITNESS: Pardon me? MR. JOHNSON: Go ahead. MR. WOOLSEY: I'm making objections to his questions. THE WITNESS: Oh. MR. WOOLSEY: Unless he tells you not to answer for some reason -- I'm just objecting for – for a time down the road. THE WITNESS: Oh, okay. MR. WOOLSEY: I'm just complaining about the type of his questions. THE WITNESS: Okay. A. She was outwardly -- Her feet were affected in that they bent one way and couldn't be relied on to be walked on, at all.

They stayed that one way. She had a pair of shoes made, and they were taken at Warm Springs and not returned. So, that was the way she was. She couldn't walk. Her hands were affected from the first joint of each finger down to the end of each finger, to where there was no feeling. And she couldn't control that, at all. So, that restricted her use of her hands completely to where she couldn't sew, she couldn't eat except if she grabbed it like a caveman would (motioning). She just couldn't do anything with her hands.

Reynolds, Lyle, (Page 7:9 to 7:20)

Q. (By Mr. Johnson) Now, how -- How did this make her feel, that she was unable to use her hands? A. When she -- MR. WOOLSEY: Objection; form. A. -- recovered with -- not recovered. When she realized that she could not control her fingers -- particularly because she had decided that in here, the one thing she could do is sew, so she had her machine in here and was sewing. When this happened, she 18 realized finally that she would never again be able to do that, and she became very depressed. And I think subsequently that's probably what killed her.

72. A true and correct copy of Lyle Reynold's deposition transcript dated August 19, 2019 is attached hereto and incorporated by reference as if set forth in full herein as Exhibit "C".

VIII. OTHER PATIENTS OF DR. RAO, DR. RAO MDPA AND OSACCN

73. The deficient, inadequate, and substandard care rendered to Mrs. Reynolds is reflective of the systemically poor care given to numerous other OSACCN and Dr. Rao MDPA patients during the relevant period that remain unidentified at this time.

IX. OBJECTIVE FALSEHOOD

74. The facts alleged above and below demonstrate that Defendants' mis-staging of cancer and subsequent unreasonable and unnecessary treatment and prescribing of cancer drugs are inconsistent with proper exercise of a physician's clinical judgment. Objective falsehood of a claim for Medicare reimbursement can be shown when a physician fails to review a patient's medical records or otherwise familiarize themselves with the patient's condition before determining the stage of a patient's cancer. *See United States v. AseraCare Inc.,* No. *16-13004*, *slip op. at 38 (11th Cir. Sept. 9, 2019) (published).* Objective falsehood may also be established when expert evidence proves that no reasonable physician could have concluded that a patient had a particular stage of cancer given the relevant medical records. *See United States v. AseraCare Inc., No.* 16-13004*,* slip op. at 38 (11th Cir. Sept. 9, 2019) (published). In this case, Relators have met both of these objective falsehood standards.

75. While there is no question that clinical judgments must be tethered to a patient's valid medical records, it is equally clear that the law is designed to give physicians meaningful latitude to make informed judgments without fear that those judgments will be second-guessed after the fact by laymen in a liability proceeding. *Id.* at 34. Dr. Rao, despite the National Comprehensive Cancer Network ("NCCN") guidelines, treated Ms. Reynolds without knowing the results of genetic testing – specifically the ALK test. A true and correct copy of the National Comprehensive Cancer Network Quick Guide article titled "Non-Small Cell Lung Cancer" is attached hereto and incorporated by reference as if set forth in full herein as Exhibit "D". This failure to obtain the ALK test readings evidences the fact that Dr. Rao's clinical judgment was not adequately tethered to Mrs. Reynolds' medical records. Moreover, CMS rulemaking commentary signals that well-founded clinical judgments should be granted deference. *Id.* at 33. Here, Dr. Rao's judgment was unfounded given her failure to obtain the ALK test results. Such

an unfounded clinical judgment cannot be relied upon nor granted any deference. Dr. Rao's judgment does not reflect a reasonable interpretation of Mrs. Reynold's medical records because the records were devoid of the critically relevant ALK test results. Dr. Rao's medical records were too thin and lacking in detail to reasonably substantiate her clinical judgment of Mrs. Reynold's stage of cancer. Based on the inadequacy of her records and her deviation from recognized NCCN guidelines, no reasonable doctor would have staged Mrs. Reynold's cancer as Stage IV. Moreover, no reasonable doctor would have continued to treat with chemotherapy without properly doing an acuity rating and continuing toxic chemo without adding up the amount of Cisplatin given in the presence of debilitating neuropathy.

76. Further evidence of the objective falsehood in Dr. Rao's records is revealed by the extended period Mrs. Reynolds lived after she was referred to hospice care. Hospice care is a type of health care that focuses on the palliation of a terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life. "Terminally ill" means that the individual "has a medical prognosis that the individual's life expectancy is 6 months or less." 42 U.S.C. § 1395x(dd)(3)(A). Dr. Rao referred Mrs. Reynolds to hospice care on June 2, 2017. However, Mrs. Reynolds did not die until May 6, 2019 – approximately 23 months after she was admitted into hospice care. If Dr. Rao's record were accurate, she would not have referred Mrs. Reynolds to hospice. Fortunately, Mrs. Reynolds sought a second opinion from Dr. Sara M. Conde regarding her cancer and neuropathy treatment. Dr. Conde, unlike Dr. Rao, made sure to get the genetic testing results that revealed Mrs. Reynolds' ALK biomarker. Dr. Conde, pursuant to the NCCN guidelines, began treating Mrs. Reynolds with Crizotinib which extended Mrs. Reynolds' life.

X. FRAUDULENT SCHEME TO BILL MEDICARE FOR UNREASONABLE AND UNNECESSARY CANCER TREATMENTS

77. Relators reallege and incorporate by reference paragraphs 1 through 76 as though fully set forth herein.

78. The cancer drugs used and treatment options available to a patient are largely predicated on what stage of cancer the patient has. When a patient's cancer is mis-staged, the cancer drugs used and treatment options available will often be unreasonable and unnecessary. For instance, as is explained in detail above, Mrs. Reynold's cancer was mis-staged and she was prescribed cancer drugs that did not work and caused her to suffer from debilitating neuropathy. Despite failing to adequately treat Mrs. Reynolds and prescribing improper chemotherapy treatments, Dr. Rao, upon information and belief, billed Medicare for the unreasonable and unnecessary drugs and treatment – which is, in fact, a fraud upon Medicare.

79. Relators allege that the mis-staging of cancer and subsequent unreasonable and unnecessary treatment and prescribing of cancer drugs forms the basis of a fraudulent scheme by Defendants to submit false bills to Medicare for reimbursement. To illustrate the mis-staging and fraudulent billing practices alleged herein Relators offer the following deposition testimony of Dr. Rao:

A. BILLING EXCERPTS

Rao, Jayasree, (Pages 145:18 to 146:9)

Q. And the patients -- does Medicare -- when you bill Medicare -- we've looked at your billing statements. When you bill Medicare, is your MDPA billing Medicare, or is Oncology San Antonio billing Medicare? A. The Oncology San Antonio because it was – it is to get drug discounts. Q. I'm going to ask you about that in a minute. So, Medicare pays Oncology San Antonio correct? A. It's a flow -- what do you say -- pass-through entity. Q. It's a pass-through

entity? A. (Witness nods head up and down.) Q. And so then the money comes where, to your PA? A. Sometimes.

Rao, Jayasree, (Page 150:8 to 151:12)

Q. So, your practice bills Medicare using the name Oncology San Antonio; is that correct? A. Yes. Q. And that's to get -- because you can get a drug discount? A. Yes. Q. And why could Oncolo- -- Why couldn't you get a drug discount just as Dr. Rao MDPA? A. There's some collective benefit. Q. What does it mean to get a drug discount? Can you explain that. A. So, if you by 100 vials of let's say cisplatin, right, we'll get instead of $6.00, maybe $6.50. Q. And what causes -- What gets you the discount? A. The volume. Q. Oh. So, in other words, you're saying if you -- if you take three or four oncologists and put their needs -- their drug needs together, you can reach the volume level to get a discount; is that right? A. Yes. Q. And is that -- Does that also cause Medicare to pay you more money? A. No. Q. It doesn't matter? A. (Witness shakes head side to side.) Q. How do -- A. Medicare is the bottom of the barrel. It pays 80 cents on the dollar.

80. A true and correct copy of Jayasree Rao, M.D.'s deposition transcript dated December 18, 2019 is attached hereto and incorporated by reference as if set forth in full herein as Exhibit "E".

B. MIS-STAGING EXCERPTS

Rao, Jayasree, (Pages 59:15 to 60:13)

Q. Now, you also started Mrs. Reynolds on carboplatin; correct? A. Uh-huh. Q. And what else? What other drugs did you start Mrs. Reynolds on in -- on or about November, early December 2015? A. Avastin and a very low dose of carboplatin. Q. And she had an allergic reaction to carboplatin; correct? A. After three or four months, yeah. Q. And so, you had to

stop that; correct? A. Yes. Q. And what did you put her on? A. Cisplatin. Q. And what is cisplatin? A. It's a cousin of carboplatin. Q. And is that a platinum-containing -- A. Uh-huh. Q. -- anticancer drug? A. Yes. Q. And one of the complications of platinum-containing anticancer drugs is something called neuropathy; correct? A. Yes.

Rao, Jayasree, (Page 86:1 to 86:10)

Q. But in your own records you diagnosed peripheral neuropathy; didn't you? A. And it says it's improving, it's grade zero, and she didn't want any therapy. Q. Well, you stopped the cisplatin; correct? A. Because she was getting weaker. Q. But, in fact, you gave how many more doses of cisplatin after you initially diagnosed the peripheral neuropathy? A. Three half doses.

Rao, Jayasree, (Pages 48:21 to 49:10)

Q. (By Dr. Mittler) My question is, even though it's relatively rare, the ALK marker in non-small cell cancer, in fact, Mrs. Reynolds had that genetic marker at the time you first saw her and all the time you treated her; correct? A. It appears to be so. Q. In other words, just so the jury understands, this is not a marker that developed later sometime in her lung cancer, right, after you saw her? Is that correct? A. Yes. It didn't develop. Q. Yeah. She had it at the beginning of her lung cancer, and she had it throughout the course of her lung cancer; correct? A. Right.

Rao, Jayasree, (Pages 181:14 to 183:15)

Q. And the point is that, at the point of time in which you initiated treatment in Mrs. Reynolds, the ALK genetic factor was known; correct? A. Not to me. Q. But it was known; correct? A. Looking back, yes, it was known. Q. And so, that was a critical factor to take into account in choosing the correct therapy for Mrs. Reynolds in November and December of 2015; correct? A.

I disagree. Q. (By Dr. Mittler) And it was the correct factor in January of 2016, in March of 2016, in June of 2016, all the way up until June of 2017, when she was under your care; correct? A. I -- MR. WOOLSEY: Form. A. -- disagree. Q. (By Dr. Mittler) And during that whole period of time, you could have obtained the results of he ALK genetic factor and you didn't; did you? A. I disagree. Q. Well, the term ALK, the three letters in capital, A-L-K, don't appear in your records, in other words, the records you and your nurse practitioner generated, anywhere; do they? A. No, because we didn't know about it. Q. Well, you didn't -- You didn't even ask about it later; correct? A. We asked about it. We don't ask every two weeks when somebody says there was nothing -- there was no tissue to do that. Q. But it was a critical factor when you first saw Mrs. Reynolds in terms of decision-making; do you agree with that? A. No, I do not. Mrs. Reynolds got the best care. Q. Well, the standard of care would have been for you to write in your record ALK and EGFR are important factors, EGFR is insufficient, and I can't get the ALK. You didn't even make a note of that; did you? A. So, Mrs. Reynolds got the best care she possibly -- possibly could have. She got first-line, second-line. She got good treatment. She lived a long time, and we gave her excellent care. Q. And one of the reasons that Mrs. Reynolds lived a long time is that you didn't have the stage correct; isn't that true? A. No, that is not true. Q. In fact, Dr. Cohen said she was Stage IIB. A. Dr. Cohen is not right.

Rao, Jayasree, (Pages 47:1 to 48:18)

You agree that the NCCN guideline on -- that you have before you in an exhibit says that, with an abnormal ALK, the first-line drug is crizotinib? Do you agree with -- A. No, I did not agree with that. Q. So, you don't agree with the NCCN guideline? A. But it doesn't say that, sir. So, NCCN guidelines are just guidelines. You have to – You have to take that and come up with a

treatment plan for your patient that best suits them. Q. Well, what -- A. NCCN doesn't say you have to give crizotinib for front-line. It doesn't say that. Q. Well, what is your basis for disagreeing with the NCCN guideline of crizotinib being the first treatment for a patient with non-small cell lung cancer, like Mrs. Reynolds, with an abnormal ALK genetic marker? A. So, non-small cell lung cancers have many types. There's adenocarcinoma. There's squamous carcinoma. Then there's large-cell and neuroendocrine. There are different types of non-small cell lung cancers. So, when you pick anything that's non-squamous -- so you have to go with what drugs are -- the patient is eligible to receive. And then you have to see what will the patient lose out if you don't do front-line or second-line or third-line. So, that's how we come up with a treatment plan. Especially when I didn't have enough issue to run tests, we -- we treated appropriately for adenocarcinoma. She responded. All the subsequent scans show that. And I think everything was done appropriately. Q. Now, you said that the ALK-positive marker is rare in non-small cell lung cancer; correct? A. Yes. Q. You gave the number, three percent; correct? A. Three to four percent, yeah. Q. But do you also agree that even though it's a rather small percentage, that Mrs. Reynolds, in fact, had it? Correct? A. I didn't know that until later.

Rao, Jayasree, (Pages 55:17 to 56:24)

Q. Do you know, from looking at Dr. Conde's records, that in fact Mrs. Reynolds did get crizotinib treatment under Dr. Conde's care? A. Yes, in 2018. Q. So, Dr. Conde gave her the treatment that the NCCN guidelines called for in 2015; correct? MR. WOOLSEY: Form. You can answer. A. Sir, Dr. Conde after one year -- after her first visit, I know Mrs. Reynolds went back to see her in 2018, and she gave her the crizotinib. Q. (By Dr. Mittler) And Mrs. Reynolds lived approximately two years after you last saw her; correct? A. So, when -- When did Mrs.

Reynolds pass away, sir? Q. Okay. For the record -- A. What date? Q. I'm going to represent to you that Mrs. Reynolds died on May 6, 2019. A. Okay. Q. And you last saw Mrs. Reynolds on June 2 -- A. In June 2017. Q. -- 2017 -- A. Yes. Q. -- correct? A. Yes. Q. So, Mrs. Reynolds, in fact, died -- MR. WOOLSEY: Don't talk over each other. Q. (By Dr. Mittler) Mrs. Reynolds, in fact, died approximately 23 months after you last saw her; correct? A. Yes.

81. Dr. Rao has been listed by the Texas Tribune as one of the top 20 doctors paid the most by Medicare in 2012 according to data from the federal Centers for Medicare and Medicaid Services. In 2012, Dr. Rao was paid 3.33 million dollars. A true and correct copy of the Texas Tribune article titled "Medicare Data Shines Light on Billions Paid to Texas Doctors" is attached hereto and incorporated by reference as if set forth in full herein as Exhibit "F". The San Antonio Express-News also reported that Dr. Rao had billed Medicare for $8.4 million in 2012 and that Dr. Rao was among just 23 physicians nationwide to collect at least $3 milling from Medicare in 2012. A true and correct copy of the San Antonio Express-News article titled "Two S.A. doctors are on list of top Medicare payments – Correction Appended" is attached hereto and incorporated by reference as if set forth in full herein as Exhibit "G".

82. In 2016, according to the testimony of Dr. Rao, she was investigated by the Centers for Medicare and Medicaid Services. The following testimony illustrates the nature of that investigation:

Rao, Jayasree, (Pages 98:10 to 99:18)

Q. Have you ever been subject to any government investigation about your cancer therapy practices? A. Not about my cancer therapy practices. Q. What have you been contacted about by the government? MR. WOOLSEY: Form. A. So, I've -- on my notes there -- there was a

time where I had to, you know, make sure that there were certain things like put the primary diagnosis -- like the format that we have now, that -- on my notes. (By Dr. Mittler) So, there was an investigation as to the adequacy of your medical records; is that correct? A. Not the medical records per se. Just about the formating of it. Q. What -- Did that investigation have to do with whether there was enough support to justify your billing? A. No. Q. So, what was the investi- -- I'm still not understanding what the investigation was about. A. So, the investigation was about that it has to have a primary diagnosis and -- What's the other one? About -- So, the way we have it now, that's how they wanted us to do the notes. That was because of certain things that happened with my former partner. It had nothing to do with billing practices or nothing like that. Q. Who -- Who conducted that investigation? A. It was an agency for the -- What do you say? I guess the CMS have somebody oversee. Q. So, "CMS" stands for Center for Medicare & Medicaid Services? A. Uh-huh.

Rao, Jayasree, (Pages 101:13 to 102:1)

DR. MITTLER: What was it? Can you read the question back, please. THE REPORTER: "What were they critical of in your progress notes?" A. That we had to have a primary diagnosis, and they were -- you know, there are certain notes where there are two handwritings. It's because I closely supervise my nurse practitioners. So, they do a note, and I always -- you know, like Mrs. Reynolds, right, I -- if there is a problem, I don't let my nurse practitioners take care of it. I will go in and I will add, you know, to the notes. So, that -- that was another question as to why there was like two signa -- two different handwritings on a note.

83. Prior to working for Oncology San Antonio Cancer Center Network, Dr. Rao Practiced with Radiation Oncology of San Antonio (“ROSA”). ROSA was the subject of two San Antonio Express

New Article regarding disputes between the members of the practice group about the intentional destruction of the practice group and the inability to meet their financial obligations. One of the San Antonio Express-News articles titled “More Troubles at S.A. Oncology Practice” reads, "A new lawsuit alleges Radiation Oncology (ROSA) officials are causing the 'intentional destruction of the medical practice' by, in part, failing to pay for cancer medications, supplies and equipment for ongoing patient treatment in two of its three divisions." A true and correct copy of the San Antonio Express-News article titled “More Troubles at S.A. Oncology Practice” is attached hereto and incorporated by reference as if set forth in full herein as Exhibit “H”. The lawsuit seems to indicate that the billing practices of ROSA were improper. The other San Antonio Express-News Article titled “Oncologists allege paperwork was forged” reads, “In September 201, Radiation Oncology and its co-president Dr, Jayasree Rao sued Dr. Rajiv Dahiya alleging he misappropriated hundreds of thousands of dollars, if not millions: from the practice to support his “investment schemes and extravagant lifestyle.” A true and correct copy of the San Antonio Express-News Article titled “Oncologists allege paperwork was forged” is attached hereto and incorporated by reference as if set forth in full herein as Exhibit “I”. For illustrative purposes, Relators direct the court to the following deposition testimony of Dr. Rao:

Rao, Jayasree, (Pages 141:7 to 142:6)

Q. And then it says that -- There's a quote by Mr. Davis, and then it says Davis represents ROSA and its co-president, Dr. Jayasree Rao, in a lawsuit against Dahiya's husband, Dr. Rajiv Dahiya, who was removed as the practice's president and is part owner in September -- and a part owner in September. Did I read that correctly? A. Yes. Q. So, were you co-president of Radiation Oncology of San Antonio? A. After all that happened. Q. So -- well, at the time of the -- Were you involved in this lawsuit, at all? A. So, I was just nobody. And we found out --

THE WITNESS: Am I supposed to answer this? MR. WOOLSEY: You can answer. THE WITNESS: Okay. A. So, in 2014, earlier in the year, we found out that our chemotherapy drugs were not being paid. So, I was supposed to be a partner, but they weren't showing me any records, any bank statements, nothing. So, I had to find somebody who will help me get to the bottom of it. So, we found out that Dr. Dahiya had swindled the company of over $20 million.

Rao, Jayasree, (Pages 158:19 to 159:3)

Q. (By Dr. Mittler) I'm going to -- before we deal with this next exhibit, the Express-News article said the Dahiyas were "suing Scott Rickenbach, ROSA's former CFO and their financial manager." Is that an accurate description of Mr. Rickenbach? A. They were all thieves and lowlifes. Q. Is Mr. Rickenbach still working in San Antonio? A. I do not have any contact with him. I hope they all are having a party somewhere in hell together.

84. As shown in great detail above, there is a significant amount of documentary and testimonial evidence showing that Defendants have mis-staged cancer and provided oncology treatments to Mrs. Reynolds that fell below the requisite standard of care. Dr. Rao and her practice have been surrounded by investigations and lawsuits stemming from their suspect medical billing practices. Relators urge the United States of America to further investigate the allegations set forth herein and intervene in this matter to fully uncover the fraudulent scheme of Defendants to submit improper chemotherapy bills to Medicare.

XI. COUNT ONE – VIOLATIONS OF THE FALSE CLAIMS ACT

85. Relators reallege and incorporate by reference paragraphs 1 through 84 as though fully set forth herein.

86. This is a claim by Relators, on behalf of The United States of Amercia, for treble damages and penalties under the False Claims Act, 31 U.S.C. 3729-3733 against Defendants for knowingly causing to be presented false claims to Government Healthcare Programs.

87. From on or about 2015, in the Western District of Texas, Defendants have knowingly and willfully violated the False Claims Act by submitting and causing false claims to be submitted.

88. Defendants have knowingly submitted Medicare claim forms for payment, knowing that such false claims would be submitted to Government Healthcare Programs for reimbursement, and knowing that such Government Healthcare Programs were unaware that they were reimbursing cancer related prescriptions for non-covered uses and/or otherwise non-covered treatments because they were not reasonable and necessary and were being submitted as part of a scheme to mis-stage cancer; and therefore false claims. By virtue of the acts described in this Complaint, Defendants knowingly presented or caused to be presented, false or fraudulent claims to the United States of America for payment or approval.

89. Defendants caused false claims to be submitted, resulting in Government Program reimbursement to healthcare providers in the millions of dollars, in violation of the False Claims Act, 31 U.S.C. § 3729 et seq.

90. The United States of America is entitled to three times the amount by which it was damaged, to be determined at trial, plus a civil penalty of not less than $5,500.00 and not more than $11,000.00 for each false claim presented or caused to be presented.

XII. PRAYER FOR RELIEF

91. WHEREFORE, Relators respectfully request this Court enter judgment against Defendants, as follows:

a. That the United States of America be awarded damages in the amount of three times the damages sustained by the USA because of the false claims alleged within this Complaint, as the Federal Civil False Claims Act, 31 U.S.C. § 3729 et seq. provides;

b. That civil penalties of $11,000 be imposed for each and every false claim that Defendants caused to be presented to the Government Healthcare Programs under the Federal False Claims Act;

c. That pre- and post-judgment interest be awarded, along with reasonable attorneys' fees, costs, and expenses which the USA and Relators necessarily incurred in bringing and pressing this case;

d. That the USA and Relators be awarded the maximum amount allowed pursuant to the Federal False Claims Act; and

e. That the Court award such other and further relief as it deems proper.

Respectfully submitted,

THE POWELL LAW FIRM

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XIII. Appendix

Exhibit A.	Expert Report of Dr. Stephen Cohen dated November 26, 2018 and Dr. Cohen's CV.
Exhibit B.	Thelma Watts Reynold's deposition transcript dated March 15, 2019.
Exhibit C.	Lyle Reynold's deposition transcript dated August 19, 2019.
Exhibit D.	National Comprehensive Cancer Network Quick Guide article titled "Non-Small Cell Lung Cancer."
Exhibit E.	Jayasree Rao, M.D.'s deposition transcript dated December 18, 2019.
Exhibit F.	Texas Tribune article titled "Medicare Data Shines Light on Billions Paid to Texas Doctors."
Exhibit G.	San Antonio Express-News article titled "Two S.A. doctors are on list of top Medicare payments – Correction Appended."
Exhibit H.	San Antonio Express-News article titled "More Troubles at S.A. Oncology Practice."
Exhibit I.	San Antonio Express-News Article titled "Oncologists allege paperwork was forged."

Exhibit A.

Expert Report of Dr. Stephen Cohen dated November 26, 2018 and Dr. Cohen's CV.

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Re: Thelma Louise Reynolds, D.O.B. 07/11/1934

Dear Dr. Mittler and Mr. Powell:

At your request I have reviewed the medical records of your client Mrs. Thelma Louise Reynolds.

I am a board certified medical oncologist who has practiced for more than 42 years, in San Antonio, Texas. I am very familiar with non-small cell lung carcinoma. I am also familiar with the possible complications due to the management of the disease, and with available multimodality therapies to treat it.

I have been certified for over 40 years with the Texas Medical Board, National Board of Medical Examiners, American Board of Internal Medicine, Subspecialty Board in Medical Oncology, Subspecialty Board in Hematology. My medical license in the State of Texas is in good standing.

My curriculum vitae is attached as **Exhibit "A"** to this report and is incorporated into this report to further support my qualifications to offer opinions on the standard of care and causation regarding the diseases, treatments, complications and injuries/damages that Thelma Louise Reynolds experienced under the care of Dr. Jayasree Rao and the Oncology San Antonio Cancer Center Network.

By virtue of my education, training, knowledge and clinical experience, and review of the medical records noted below, I am qualified to give expert opinions on the applicable standards of care, the breeches of the standards of care, and causal relationships between breeches of the standards of care and the harms and injuries sustained by Thelma Reynolds, specifically with the diagnosis, staging, prognosis, treatments, management, and complications of non-small cell lung carcinoma and the other medical conditions experienced by Mrs. Reynolds which are noted in my report below and int the medical records I reviewed.

I am familiar with the relevant disease processes and medical evaluations and treatments pertinent to this case by virtue of my education, knowledge, training, experience and actual hands on treatment of patients with conditions like or similar to those experienced by Mrs. Reynolds.

All of the opinions contained in this report are being provided on a "more likely than not" standard or put another way, a "within reasonable medical probability" standard.

LEGAL DEFINITIONS

I have been provided with the following legal definitions which I will follow in this report.

"NEGLIGENCE," when used with respect to the conduct of the physicians, health care providers listed below means failure to use ordinary care, that is, failing to do that which a physician, health care provider of ordinary prudence would have done under the same or similar circumstances or doing that which a physician, health care provider of ordinary prudence would not have done under the same or similar circumstances.

"ORDINARY CARE," when used with respect to the conduct of the physicians, health care providers listed below means that degree of care that a physician, health care provider of ordinary prudence would use under the same or similar circumstances.

"PROXIMATE CAUSE," when used with respect to the conduct of the physicians, health care providers listed below means that cause which, in a natural and continuous sequence, produces an event, and without which cause such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that a physician, health care provider using ordinary care would have foreseen that the event, or some similar event, might reasonably result there from. There may be more than one proximate cause of an event.

"GROSS NEGLIGENCE" means: (a) An act or omission by the physicians, health care providers listed below: (I) which, when viewed objectively from the standpoint of physicians, or health care providers at the time of its occurrence, involved an extreme degree of risk, considering the probability and magnitude of the potential harm to others; and (ii) of which physicians, health care providers have actual, subjective awareness of the risk involved, but nevertheless proceeds with conscious indifference to the rights, safety, or welfare of others. The Standard of Care requires that a physician, hospital, and all health care providers use ordinary care.

I have reviewed the following records related to Thelma Reynolds:

1. Medical records of Baptist Health Systems;
2. Medical records Baptist M & S Imaging;
3. Medical & billing records of Oncology San Antonio Cancer Center Network;
4. Medical records of Jayasree Rao M.D.;
5. Medical Records Southwest General Hospital;
6. Literature. Gridelli, Cesare et al. "Cisplatin-Based First-Line Treatment of Elderly Patients With Advanced Non-Small-Cell Lung Cancer: Joint Analysis of MILES-

7. 3 and MILES-4 Phase III Trials." J Clin Oncol, 09/2018, **Volume** 36, **Issue** 25, pp. 2585–2592;
8. Literature. Bunn, P.A., et al. "Systemic Therapy for Elderly Patients With Advanced Non-Small Cell Lung Cancers." J Clin Oncol, 09/2018, **Volume** 36, **Issue** 25, pp. 2571–2574:
9. Literature. Solomon BJ et al. "First-Line Crizotinib versus Chemotherapy in ALK-Positive Lung Cancer." NEJM 12/04/2014, Vol 371, Iss 23, pp. 2167-2177; and
10. Literature. Lung Cancer Research Foundation and the Lung Cancer Mutation Consortium. http://www.lungcancerresearchfoundation.org/research/lung-cancer-mutation-consortium.

Firstly, I will briefly summarize the information available to me.

Mrs. Reynolds was 81 years old when hospitalized with diverticulitis in 4/2015. The records of Dr. Jayasree Rao state 04/15/15 x-ray showed pneumonia in right upper lobe. The Chest CT was completed on 04/27/2015. A CXR 7/29/15 did show a right upper infiltrate with consolidation.

I have concluded that subsequent follow up of the lung changes included a negative bronchoscopy, and a PET/CT scan 7/8/15, and 10/02/2015 showed left upper lung lobe opacities. This PET/CT scan comparison 7/8/15 to 10/2/15 showed no significant changes. I did find the 10/02/15 PET/CT showed a 5.7x2.3 cm mass-like posterior upper lobe lesion bordering the fissure. The lesion's SUV was 9,4. In addition the scan showed a more caudal stable left upper lobe lesion of 2.7 x2.8 cm with a SUV 5.6. The hypermetabolic lesions suggest malignancy, along with infectious and inflammatory disease. The right upper lobe showed a 1.7 cm pleuronodular opacity with SUV 1.6 suggesting infectious/infiltrative disease.

Mrs. Reynolds had a thoracic PET/CT scan on 04/27/2015 which I noted above. I am concluding the 4/27/15, 7/8/15, 10/02/17 chest PET/CT scans showed no significant changes. They showed extensive bilateral upper lobe lesions and basilar multilobular atelectasis and fibrosis as well.

In any case, Mrs. Reynolds had a lung biopsy of the left upper lobe of lung on 11/16/2015. Six weeks after the most recent PET/CT chest scan, the biopsy revealed an adenocarcinoma. Mrs. Reynold's doctors at that time was Dr. Hector L. Gomez, and Dr. Christopher Joseph Muniz. I have not seen their records. The left upper lobe core biopsy revealed an adenocarcinoma, consistent with a lung primary. The biopsy was read by Dr. Nancy B. Banks a pathologist at Baptist Medical Center, San Antonio, Texas. The surgical pathology report revealed Dr. Banks discussed the diagnosis with Dr. Hector Gomez on 11/17//2015. Dr. Banks also reported the atypical cell findings to Dr. Christopher Muniz on 10/16/17. The report also noted that testing for critical molecular targeting, the ALK and EGFR markers, was to be done. An addendum to the pathology report dated 11/23/2015 showed the ALK gene rearrangement was detected in 37% of cells, and the EGFR test was not done due to inadequate tumor tissue. Importantly, the results of the ALK and EGFR testing were not in doctor Rao's medical records and those two biomarkers were never referred to in any of Dr. Rao's treatment records of Mrs. Reynolds.

At the time of the diagnosis of her lung cancer Mrs. Reynolds was in reasonably good health. She was recently retired but was active and ambulatory. She had a history of diverticulitis, with the last episode 4/15/2015, about 7 months before receiving the diagnosis of adenocarcinoma of the lung and receiving Avastin therapy. She had hyperlipidemia and was on antilipid meds. She also had controlled BP with antihypertensive drugs. In addition, she was medicated for anxiety and depression.

She did have a remote history of smoking for 8 years.

Dr. Jayasree Rao provided an oncology consultation on 11/20/15. Her consultation on Mrs. Reynolds revealed she was asymptomatic at the time of diagnosis of adenocarcinoma of the lung. Her review of systems was negative as related to her neoplasm. Dr. Rao stated she reviewed the laboratory and diagnostic studies. Except for stating she had adenocarcinoma she cited no lab results and no other pathology. She does not discuss any PET/CT scan findings but concludes she suspected Stage IV disease radiographically. She did not mention any specific evidence image-wise that would support that stage of disease.

Dr. Rao told Mrs. Reynolds and her family that she had advanced stage disease and that her goal was to palliate and control her disease process. She indicated the goals of treatment were to prolong her life and to provide quality of life.

Dr Rao started Mrs. Reynolds on Avastin and Carboplatin therapy on 11/27/2015.
She indicated that Mrs. Reynolds had a number of treatment options, but only considered chemotherapy/angiogenesis inhibitor treatment. She did not consider Taxol given her age. Dr. Rao did not mention the possibilities of surgery, radiation therapy, targeted therapy or even observation as reasonable alternatives.

She did note that Bevacizumab (Avastin) was associated with the risks of hypertension and bowel perforation, and informed Mrs. Reynolds and her family of these complications.

Dr. Rao made arrangements for Mrs. Reynolds to get an intravenous catheter placement for the administration of drugs.

In less than 1 month after starting Carboplatin and Avastin, Mrs. Reynolds was having gastrointestinal symptoms requiring cessation/delay of her treatment for toxicity.

Dr. Rao's 12/23/15 note points out Mrs. Reynolds is not a surgical candidate and was given Avastin/Taxol. Neither of these were true. According to my analysis Mrs. Reynolds was a surgical candidate and the medical records should have reflected that she received Avastin and carboplatin.

Dr. Rao's initial note in her office suggested stage IV disease.

It was known that her N and M clinical staging were 0 based on a number of negative PET/CT thorax and body scans. There are no extra thoracic or nodal metastases identified on her scans. I believe her initial T Stage was T3. She should have been Staged IIB. Dr. Rao's suggestion that Mrs. Reynolds had stage IV disease was not demonstrated by any imaging testing, and she made no notation of these test results to corroborate her conclusion about disease stage.

Classically T, N, & M The classic staging of lung cancer staging is done by the following criteria (T = Tumor, N=Nodes, M=metastasis):

Stage IA-T1N0M0
Stage IB-T2N0M0
Stage IIA-T1N1M0
Stage IIB-T2N1M0, T3N0M0
Stage IIIA-T3N1M0, T1-T3N2M0
Stage IIIB-T4 Any NM Any T N3M0
Stage IV-Any T Any N M1
TX-positive cancer cells without primary tumor on imaging or bronchoscopy T0-No evidence of primary tumor T is-carcinoma-in-situ T1-Tumor≤ 3 cm, surrounded by lung or visceral pleura, without bronchoscopic evidence of invasion more proximal than the lobar bronchus.
T1a:≤2cm
T1b:>2cm but≤3cm
T2-Tumor with any of the following features: > 3 cm in greatest dimension, involves mainstem bronchus, ≥2 cm distal to the carina, invades the visceral pleura, associated with atelectasis or obstructive pneumonitis that extends to the hilar region but does not involve the entire lung
T2a:>3cm but≤5cm
T2b: >5cmbut≤7cm, Or tumors≤ 7 cm with invasion of visceral pleura, atelectasis of less than entire lung, proximal extent at least 2 cm from carina T3-Tumor of any size that invades any of the following: chest wall (including superior sulcus tumors), diaphragm, mediastinal pleura, parietal pericardium: or tumor in the main bronchus < 2 cm distal to the carina, but without involvement of the carina; or associated atelectasis or obstructive pneumonitis of the entire lung
T3- tumors> 7 cm or with: Direct invasion of chest wall, diaphragm, phrenic nerve, mediastinal pleura, parietal pericardium, main bronchus< 2 cm from carina (without involvement of carina) and tumor nodules in the same lobe as the primary tumor.
T3 -tumors associated with additional tumor nodules (ATNs) in the same lobe as the primary tumor
T4 –Tumor of any size that invades any of the following: mediastinum, heart, great vessels, trachea, esophagus, vertebral body, carina: or tumor with a malignant pleural or pericardial effusion, metastatic tumor nodules in different lobe from the primary tumor.
NX-Regional lymph nodes cannot be assessed N0-No regional lymph node metastases N1-Metastasis to ipsilateral peribronchial and/or ipsilateral hilar lymph nodes, and involvement of intrapulmonary nodes by direct extension of the primary tumor.
N2-Metastasis to ipsilateral mediastinal and/ or subcarinal lymph node(s).
N3-Metastasis to contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene, or supraclavicular lymph node(s).
MX-Presence of distant metastasis cannot be assessed.
M0-No distant metastasis
M1-Distant metastasis present including metastatic tumor nodules in the ipsilateral nonprimary tumor lobes of the lung.
M1a: malignant pleural or pericardial effusion, pleural nodules or nodules in contralateral lung
M1b: distant metastases
One of its aims is to determine which patients are resectable or not.
Determines extent of disease and stratifies patients into therapeutic and prognostic groups.

Dr. Rao's pretreatment evaluations should have included Mrs. Reynolds' history, physical exam, and pertinent radiographic images, the lung biopsy pathology results and the results of the ALK rearrangement test and the EFGR assay done on the tumor. The fact that she did not get the ALK results is clearly a failure in the standard of care. Furthermore, this information never appeared in any of Dr. Rao's medical records of Mrs. Reynolds which is also below the standard of care, at every subsequent visit.

Shortly after Mrs. Reynold's treatment started, she had gastrointestinal symptoms and a suspicion of bowel perforation. The Avastin was eliminated from subsequent treatment, as it was suspected to be the cause of her bowel perforation. Interestingly, many progress notes say she was started on palliative treatment with carboplatinum and Avastin and tolerated it well.

Actually, Mrs. Reynolds was started on treatment with Carboplatinum and Avastin on 11/27/15, and the 12/23/15 note says she was quite ill with gastrointestinal complaints. Getting drastically ill within 1 month of initiation of therapy can hardly be reconciled with "it was tolerated well". This inconsistency of the progress notes and the reality of the clinical situation, was a common finding in the medical record, and will be addressed further. Dr. Rao's use of the term "palliative care" does not apply to a patient who is Stage II B who is more likely than not curable.

Mrs. Reynolds was switched to a combination of Cisplatinum and Alimta.
Mrs. Reynolds' carboplatin therapy was discontinued because of an allergic reaction.
Unfortunately, this fact was never presented in the cut and paste present illness notes.
Cisplatinum is significantly more toxic than carboplatin, particularly for neuropathy. This omission from the present illness record is significant. In fact, the Cisplatinum was the cause of Mrs. Reynolds debilitating neuropathy which I will discuss further.

Mrs. Reynolds remained on Cisplatinum/Alimta for quite a while, about 1 year. Because of neutropenia, nausea, fatigue, anemia, mucositis, weakness and weight loss the treatment schedule for Cisplatinum was changed to a weekly regimen.

According to Dr. Rao, Mrs. Reynolds lung cancer was Stage IV.
This is in error, as there was never evidence of metastatic disease outside of the left upper lobe of the lung. This misinterpretation of the facts by Dr. Rao fails the standard of care. The record repeatedly states she has metastatic and unresectable disease, not confirmed by the facts. This is a major medical error and is both negligence and gross negligence.

On 10/21/16 it is noted for the first time Mrs. Reynolds had uncontrolled hypertension due to Avastin. Yet, Avastin was stopped about 11 months previous.

The cut and paste review of systems and physical examinations repeatedly reflect no neurological symptoms or findings, until 12/9/16. At that time, bilateral lower extremity weakness and an unsteady gait was noted. Dr. Rao indicated the presence of grade 0-1 peripheral neuropathy. On the same date, hypomagnesia, another side effect of Cisplatinum was reported.

On 12/30/16, three weeks after noting the presence of a peripheral neuropathy, Dr. Rao states there was no peripheral neuropathy present, but unsteady gait was present. Mrs. Reynolds

unsteady gait was related to Cisplatinum induced motor neuropathy. There was no evidence that that Mrs. Reynolds had paresthesias. It is clear her neuropathy was primarily motor and underrecognized by Dr. Rao and her medical/nursing staff. The delayed recognition of her neuropathy contributed to her prolonged exposure to Cisplatinum. As a result, she developed severe, life altering, permanent peripheral neuropathy of hands and legs.

I should point out that on a number of visits Mrs. Reynolds was seen by Physicians Assistants with oversight by Dr. Rao.

On 1/10/17 no coordination abnormalities or motor deficits were noted but unsteady gait persisted. Because of fatigue and weakness, switching therapy to Opdivo was considered.

Mrs. Reynolds was switched to Opdivo on 1/20/17 due to declining performance status from Cisplatinum/Alimta, and suspected progression of disease.

On 3/17/17 the progress note revealed unsteady gait, use of a walker and peripheral neuropathy of her hands. Gabapentin was initiated at a homeopathic dose. A similar note exists for 5/5/17.

As I review the records, Mrs. Reynolds experienced significant toxicities from her chemotherapy/Avastin regimens including: bowel perforation, hypertension, mucositis, anemia, thrombocytopenia, neutropenia, hyponatremia, hypomagmesemia, fatigue, weakness, weight loss and severe peripheral neuropathy.

Mrs. Reynolds was diagnosed with a left upper lobe adenocarcinoma on 11/16/15. Interestingly, a chest X-ray ordered by Dr. Hector Gomez on 7/29/15 indicated a right upper lobe infiltrate suggesting pneumonia. An aspirational biopsy of the right upper lobe was done on 7/8/15 at Southwest General hospital with negative cytology for cancer and a negative bacterial culture. No mention of a left upper lobe lesion(s) was noted. This suggests the left upper lobe findings were not identifiable by chest X-ray.

On 04/27/2015 Mrs. Reynolds had a PET/CT. That study was essential in evaluating and staging her cancer for Mrs. Reynolds appropriate medical management. I do not have the images of her subsequent PET/CT scans for review. Extracting from reviewing the available imaging reports: 7/18/17, 10/2/15, 4/29/16, 8/16/16, 12/12/16, 5/26/17 PET/CT scans were done.

The results of these scans showed mostly stable disease, with decreased masses and hypermetabolism on 4/29/16. None of the reports from Dr. Rao's notes measure an objective response on these scans. By RECIST measurable criteria (categorizes quantitative tumor size changes into complete response, partial response, stable disease, or progressive disease) I could not find any significant PET/CT scan changes among the scan reports. More importantly, no imaging study ever showed progression to Stage IV metastatic disease.

The Mrs. Reynold's record noted Mrs. Reynolds was taking Evista, but never indicated why. This omission of information is significant. Did she have a history of breast cancer? Did she have breast adenocarcinoma metastatic to lung? Dr. Rao's omission of information about a hormonal drug primarily used for breast cancer fails the standard of care.

I have reached the following opinions about Mrs. Reynold care provider Dr. Jayasree Rao & Oncology San Antonio Cancer Center Network:

Mrs. Reynolds had Stage IIB disease. Dr. Rao mis-staged her disease 11/16/2015 as Stage IV and on all subsequent visits. This is a failure in the standard of care.
Mrs. Reynolds cancer was resectable and curable at that time, with surgery-left upper lobectomy.
Mrs. Reynolds was asymptomatic from her cancer on 11/15/15.
Mrs. Reynolds had stable findings from 4/27/2015 to 10/2/15 on PET/CT scans.
The appropriate management choices for an asymptomatic 81-year-old patient with confined low-grade adenocarcinoma, such as Mrs. Reynolds, would be left upper lobectomy, possible radiation, possible ALK kinase inhibitor, or observation.

By Dr. Rao's incorrectly diagnosing Mrs. Reynolds' cancer stage Mrs. Reynolds lost the chance for cure. This is a significant failure in the standard of care. The toxicities endured by Mrs. Reynolds, have made employing curative therapy impossible.

Mrs. Reynolds had an ALK positive lesion.
The significance of ALK gene is indicated by the fact the pathologist performed this test as part of the routine study of a lung cancer.

If Mrs. Reynolds was staged IV by Dr. Rao, an ALK kinase inhibitor, Crizotinib should have been the treatment of choice. (Solomon BJ et al, NEJM 2014).

Dr. Rao should have known that targeted therapy with Crizotinib was the treatment of choice in Stage IV adenocarcinoma of the lung in patients with ALK positive disease. Not having this knowledge and not employing this therapy failed the standard of care.

Crizotinib is much less toxic and more efficacious than chemotherapy for ALK positive lung cancers. Failure to use Crizotinib, and using the other inappropriate neurotoxic agents I have noted above, is the direct and proximate cause of Mrs. Reynolds permanent and disabling neuropathy.

Failing to consider an ALK kinase inhibitor is below the standard of care and is negligent and grossly negligent. Remarkably, Dr. Rao failed to get the ALK results. This failed the standard of care. Dr Rao made no inquiry and/or ignored the ALK results which is below the standard of care, both negligent and grossly negligent and a direct and proximate cause of Dr. Rao's use of inappropriate chemotherapeutic agents which caused permanent, disabling neuropathy.

This failure and the failure to appropriately stage Mrs. Reynolds cancer led to the inappropriate administration of toxic chemotherapy.

The toxic chemotherapy of Cisplatinum/Alimta caused Mrs. Reynolds marked clinical deterioration, with severe peripheral neuropathy, which has been permanent and disabling.

Dr. Rao also failed to search out the results of Mrs. Reynold's EGFR result. There are a number of tyrosine kinase oral inhibitors that would be preferable if this test was positive.

Dr. Rao also failed the standard of care by administering Avastin to a patient with recent diverticular disease that required hospitalization. This resulted in a perforated bowel which was directly caused by the Avastin.

Bowel disease is a relative contraindication to the use of bevacizumab as it leads to a significant risk of bowel perforation, which Mrs. Reynolds experienced. A prudent approach by an oncologist should have been to avoid the risks of bowel perforation in a patient with symptomatic bowel disease, given its small chance of benefit. The risk of bowel perforation is so significant in a patient like Mrs. Reynold with a history of diverticulitis disease that is should preclude its usage.

My assessment is Mrs. Reynolds had Stage IIB adenocarcinoma of the lung. The lesion was curable at the time of diagnosis. The upstaging/ wrong staging to Stage IV by Dr. Rao failed the standard of care by confusing probable lepidic spread as metastatic disease. This error caused Dr. Rao to give Mrs. Reynolds toxic palliative chemotherapy instead of employing curative treatment. She incorrectly labeled Mrs. Reynolds' disease non resectable and noncurative.
Dr. Rao did not seek the ALK results which were readily available, and should have been the basis for targeted therapy with Crizitonib

Crizinotib would have been the standard therapy in the setting of lung adenocarcinoma in an 81-year-old. She therefore failed the standard of care in not seeking this information, which is a causative reason for her error in administering therapy that caused a bowel perforation, numerous side effects outlined above, and life altering permanent peripheral neuropathy.
Failing to consider and use Crizotinib was a failure in the standard of care.

Finally, I believe Mrs. Reynolds had bronchoalveolar adenocarcinoma. This type of cancer is TTF1 and CK7 positive, as was Mrs. Reynold's tumor. Furthermore, this type of lesion is slow growing, susceptible to lepidic growth and limited aggressivity. This tumor would explain the local tumor involvement, absence of extrathoracic metastases, lack of significant measurable response to chemotherapy, and minimal, if any progression of tumor.
Dr. Rao failed the standard of care by not seeking the pathological results of a positive ALK, TTF1 and CK7 marker.

Molecular testing is mandatory and is the standard of care in every lung cancer biopsy specimen obtained. Molecular testing is required in all stage IV patients with adenocarcinoma of the lung (Standardofcare.com) to avoid chemotherapy toxicity, and to choose the most efficacious therapy.

The Lung Cancer Mutation Consortium in the United States demonstrated that the median survival of patients without driver mutations, with drivers mutations but not treated with targeted therapy, and with driver mutations and treated with targeted therapy was 2.08 years, 2.38 years, and 3.49 years, respectively in patients with Stage IV disease. This suggests that if Mrs. Reynolds was treated appropriately with Crizitonib (even with inappropriately diagnosed Stage IV disease) she would survived many years with minimal toxicity. In fact, Mrs. Reynolds has survived but with terrible non- curable debilitating neuropathy which is a direct result of Dr. Rao's mistreating and mis staging and inappropriately treating her tumor.

To summarize my analysis of the care provided to Mrs. Rey by Dr. Rao and Oncology San Antonio Cancer Center Network:

Breech of Standard of Care of Jayasree Rao M.D.

Dr. Rao failed to meet the minimum standard of care in caring for Mrs. Reynolds. The following deviations from the standard of care are noted and apply to Dr. Rao.

1. Failed to properly stage Mrs. Reynolds cancer. This occurred at every visit to Dr. Rao's office.
2. Failed to recognize at every medical visit that that Mrs. Reynold was mis staged and more likely than not curable and should have led to curative left upper lobectomy.
3. Administered chemotherapy/Cisplatinum when a less toxic regimen was available based on ALK molecular target.
4. Failed to recognize that there was an alternative available to chemotherapy based on patients ALK results Crizotinib.
5. Failed to obtain ALK and EGFR results and incorporating that into Mrs. Reynolds treatment strategy throughout treatment.
6. Failed to take in to account the TTFI and CK7 histological markers which more likely than not indicates a bronchoalveolar adenocarcinoma which is less aggressive, more localized and a more likely curable tumor throughout treatment.
7. Failed to keep adequate medical records:
    a. Dr. Rao's use of the term palliative care does not apply to a patient who is Stage II B;
    b. Inconsistency of medical records; failed to timely note motor neuropathy complication of therapy;
    c. 12/23/15 note says she was quite ill with gastrointestinal complaints. Getting drastically ill within 1 month of initiation of therapy can hardly be reconciled with "it was tolerated well.
8. Administered Avistan in a patient with known diverticular disease.
9. Failed to timely recognize Cisplatinum induced peripheral neuropathy.
10. The delayed recognition of her neuropathy contributed to her prolonged exposure to Cisplatinum. As a result, she developed severe, life altering, uncurable, peripheral neuropathy of hands and legs.
11. Erroneously diagnosed the need for hospice as end of life due to cancer when it was reaction to the extreme toxicity from Cisplatinum.

The Standard of Care for Jayasree Rao M.D.

The minimum standard of care for Dr. Jayasree Rao in caring for Mrs. Reynolds was as follows:

1. Properly stage Mrs. Reynolds cancer at every visit to Dr. Rao's office.
2. Recognize at every medical visit that that Mrs. Reynold was mis staged and more likely than not curable with appropriate therapy.
3. Do Not administer chemotherapy/Cisplatinum when a less toxic regimen was available based on ALK molecular target.

4. Recognize that there was an alternative better/ more appropriate treatment to chemotherapy based on patients ALK results, namely, Crizotinib.
5. Obtain ALK and EGFR results and incorporate those results into Mrs. Reynolds treatment strategy throughout treatment.
6. Take into account the TTFI and CK7 histological markers which more likely than not indicated a bronchoalveolar adenocarcinoma which is less aggressive, more localized and a more likely curable tumor throughout treatment.
7. Keep adequate medical records:
    a. Do not use the term "palliative care" for a patient who is Stage II B;
    b. Timely note motor neuropathy complication of therapy;
    c. do not use the term, : "it was tolerated well" when Avastin therapy 12/23/15 note says she was quite ill with gastrointestinal complaints. Getting drastically ill within 1 month of initiation of therapy can hardly be reconciled with "it was tolerated well".
8. Do Not administer Avastin in a patient with known diverticular disease
9. Timely recognize Cisplatinum induced peripheral neuropathy and take appropriate action
10. Timely recognize her neuropathy contributed to her prolonged exposure to Cisplatinum. As a result, she developed severe, life altering, uncurable, peripheral neuropathy of hands and legs.
11. Do Not diagnose the need for hospice as end of life care due to cancer when it was reaction to the extreme toxicity from Cisplatinum.

***Analysis of Causation and Damages Pertaining to Dr. Jayasree* Rao**

Dr. Jayasree Rao's failure to meet the minimum standard of care in caring for Mrs. Thelma Reynolds was a direct and proximate cause of damages to Mrs. Reynolds in the following ways:

1. Failure to properly stage Mrs. Reynolds cancer. This occurred at every visit to Dr. Rao's office. This was a direct and proximate cause of mistreatment with toxic chemotherapeutic agents as noted above which caused permanent disabling neuropathy and Mrs. Reynolds being independent and able to care for herself to her being placed in assisted living. It also caused severe depression and pain, suffering, and emotional distress and increased expenses associated with treatments and assisted living.
2. Failed to recognize at every medical visit that that Mrs. Reynold was mis staged and more likely than not curable with appropriate therapy. This was a direct and proximate cause of mistreatment with toxic chemotherapeutic agents as noted above which caused permanent disabling neuropathy and Mrs. Reynolds being independent and able to care for herself to her being placed in assisted living. It also caused severe depression and pain, suffering, and emotional distress and increased expenses associated with treatments and assisted living.
3. Administered chemotherapy/Cisplatinum when a less toxic regimen was available based on ALK molecular target. This was a direct and proximate cause of mistreatment with toxic chemotherapeutic agents as noted above which caused permanent disabling neuropathy and Mrs. Reynolds being independent and able to care for herself to her being placed in assisted living. It also caused severe depression and pain, suffering, and emotional distress and increased expenses associated with treatments and assisted living
4. Failed to recognize that there was an alternative available to chemotherapy based on patients ALK results Crizotinib. This was a direct and proximate cause of mistreatment with toxic

chemotherapeutic agents as noted above which caused permanent disabling neuropathy and Mrs. Reynolds being independent and able to care for herself to her being placed in assisted living. It also caused severe depression and pain, suffering, and emotional distress and increased expenses associated with treatments and assisted living

5. Failed to obtain ALK and EGFR results and incorporating that into Mrs. Reynolds treatment strategy throughout treatment. This was a direct and proximate cause of mistreatment with toxic chemotherapeutic agents as noted above which caused permanent disabling neuropathy and Mrs. Reynolds being independent and able to care for herself to her being placed in assisted living. It also caused severe depression and pain, suffering, and emotional distress and increased expenses associated with treatments and assisted living

6. Failed to take in to account the TTFI and CK7 histological markers which more likely than not indicates a bronchoalveolar adenocarcinoma which is less aggressive, more localized and a more likely curable tumor throughout treatment. This was a direct and proximate cause of mistreatment with toxic chemotherapeutic agents as noted above which caused permanent disabling neuropathy and Mrs. Reynolds being independent and able to care for herself to her being placed in assisted living. It also caused severe depression and pain, suffering, and emotional distress and increased expenses associated with treatments and assisted living

7. Failed to keep adequate medical records

a. Dr. Rao's use of the term palliative care does not apply to a patient who is Stage II B;

b. Inconsistency of medical records; failed to timely note motor neuropathy complication of therapy

c. 12/23/15 progress note says she was quite ill with gastrointestinal complaints. Getting drastically ill within 1 month of initiation of therapy can hardly be reconciled with "it was tolerated well

These record keeping failures delayed the recognition of life altering permanent neuropathy and was a direct and proximate cause of mistreatment with toxic chemotherapeutic agents as noted above which caused permanent disabling neuropathy and Mrs. Reynolds being independent and able to care for herself to her being placed in assisted living. It also caused severe depression and pain, suffering, and emotional distress and increased expenses associated with treatments and assisted living.

The delayed recognition of Mrs. Reynold's neuropathy contributed to her prolonged exposure to Cisplatinum. As a result, she developed severe, life altering, uncurable, peripheral neuropathy of hands and legs. This was a direct and proximate cause of mistreatment with toxic chemotherapeutic agents as noted above which caused permanent disabling neuropathy and Mrs. Reynolds being independent and able to care for herself to her being placed in assisted living. It also caused severe depression and pain, suffering, and emotional distress and increased expenses associated with treatments and assisted living.

9. Administered Avastin in a patient with known diverticular disease. This was a direct and proximate cause of bowel perforation and the pain and suffering and expenses associated with this along with the weakening of an elderly patient such as Mrs. Reynolds who was subjected to a serious illness that should not have occurred but for the negligence of Dr. Rao. This was a direct and proximate cause of mistreatment with toxic chemotherapeutic agents as noted above which caused permanent disabling neuropathy and Mrs. Reynolds being independent and able to care for herself to her being placed in assisted living. It also caused severe depression and pain, suffering, and emotional distress and increased expenses associated with treatments and assisted

living.
10. Failed to timely recognize Cisplatinum induced peripheral neuropathy. This was a direct and proximate cause of mistreatment with toxic chemotherapeutic agents as noted above which caused permanent disabling neuropathy and Mrs. Reynolds being independent and able to care for herself to her being placed in assisted living. It also caused severe depression and pain, suffering, and emotional distress and increased expenses associated with treatments and assisted living.
11. Erroneously diagnosed the need for hospice as end of life due to cancer when it was reaction to the extreme toxicity from Cisplatinum. This was as direct and proximate cause of depression and emotional distress in a patient who was negligently told she had 6 months or less to live when in fact she had much more time to live but suffered with the spectre of impending death due to Dr. Rao's negligent disease staging and treatments which caused permanent life threatening neuropathy. I have been told that Mrs. Reynolds effectively lost the will to live which was not due to her disease but rather due to the toxic, wrong chemotherapies administered to her by Dr. Rao and her staff at Oncology

Gross Negligence:

Dr. Jayasree Rao was grossly negligent by inappropriately staging Mrs. Reynolds, failing to give Mrs. Reynolds the opportunity to be cured of her cancer, by not obtaining and incorporating into the treatment evaluation protocol the results of molecular markers, specifically, the ALK marker, which was available at all times to Dr. Rao and her staff, and as a result Dr. Rao was consciously indifferent to the health and safety of Mrs. Reynolds, and treated her with toxic neuropathic chemotherapy, inappropriate at all times for the tumor Mrs. Reynolds actually had, causing Mrs. Reynolds severe, debilitating, incurable, peripheral neuropathy (permanent damage to nerves) which has required Mrs. Reynolds to go from independent living to assisted living, with associated costs and life stresses associated with having to give up her independence. In addition, Mrs. Reynolds became so debilitated from the neuropathy that due to her weakness and exhaustion and false assessment by Dr. Rao and her staff that she was dying, she agreed to enter hospice, a program designed by law to be only for those with 6 or fewer months to live. This was a false and negligent referral by Dr. Rao based on a negligent diagnosis and assessment and negligent and grossly negligent treatment that caused debilitation and permanent neuropathy.

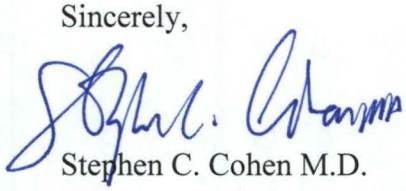
I will assume that Dr. Rao is an employee of Oncology San Antonio Cancer Center Network as are the employees who cared for Mrs. Reynolds at Dr. Rao's direction. And as such, Oncology San Antonio Cancer Center Network is vicariously liable for the negligence and gross negligence of Dr. Rao and its employees as I have specified in detail above. All of my criticism and causation analysis and damages analysis for Dr. Rao apply equally to Oncology San Antonio Cancer Center Network and its employees.

Conclusion:
Based upon my review of the medical records, and based upon my knowledge, training and experience, it is my opinion that based upon reasonable medical probability, Mrs. Thelma Reynolds suffered pain, suffering, extra medical costs, and emotional distress in addition to the probability of future pain and suffering due to negligence and gross negligence of Dr. Rao and Oncology San Antonio Cancer Center Network, as explained in detail above. Dr. Rao failed to stage Mrs. Reynold's cancer correctly, failed to incorporate the ALK markers into a treatment plan at all times, and treated Mrs. Reynolds with the wrong chemotherapeutic drugs which

caused severe debilitating permanent neuropathy.

As more materials become available in this case, I reserve the right to supplement or amend this report.

Sincerely,



Stephen C. Cohen M.D.

Encls. Exhibit A CV
Exhibit B Any research?

CURRICULUM VITAE

NAME: STEPHEN CARL COHEN, M.D.

BORN: Brooklyn, New York
April 20, 1944

MARRIED: Elaine Bergman
December 25, 1965

CHILDREN: Andrew Seth, born July 27, 1969
Harris Lee, born August 15, 1971

SCHOOLS:
1961 Thomas Jefferson High School
1965 Univ. of Miami, Coral Gables, Florida (B.S.)
1969 Univ. of Oklahoma School of Medicine, (M.D.) Medicine Internist

TRAINING:
1971 Univ. of Washington, Internal Medicine Residency
1974 Walter Reed, Washington, D.C., Fellowship Hematology/Oncology

BOARD CERTIFICATION: National Board of Medical Examiners, 1970
American Board of Internal Medicine, 1974
Subspecialty Board in Medical Oncology, 1975
Subspecialty Board in Hematology, 1976
Post Surgeon, Ft. Leslie J. McNair, Washington, D.C.

EMPLOYMENT:
1974-1975 Asst. Chief, Hematology - Oncology Service, U.S. Army, Fitzsimmons Army Hospital, Denver, Colorado

1975-1978 Practice of Medical Oncology with Southwest Oncology Associates, P.A., San Antonio, Texas
1978 – 10/2009 - Private Practice of Medical Oncology, San Antonio Tumor & Blood Clinic, P.A.
1992 – 1999 - Healthcare Analysis & Review, Inc., San Antonio, Texas
1998 – Present – President, The Standard of Care
1999 – Present – President, Sign of the Times
2009 – Present – Private Medical Practice; Medical Therapy & Research, PLLC
2014 California Medical Weight Management

SOCIETIES: Alpha Omega Alpha
Bexar County Medical Society
(Vice President, 1986; President, 1987)
South Texas Regional Blood Bank
(President, 1985-1986)
Texas Medical Association
American Medical Association
Physicians Who Care

(President, 1985-1996)
(National Vice President, 1989-1997)

National President, 1997-1998)
Baptist Medical System
(Chief of Staff, Northeast, 1988)
(President Medical Executive Board, 1990)
Healthcare Analysis & Review, Inc. 1994-
American Society of Hematology
American Society of Oncology
American College of Physicians

LICENSURE: Texas, 1975

TEACHING POSITION: 1985 Clinical Professor Medicine,
The University of Texas Health Science Center
at San Antonio, Texas.

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SPEECHES AND PRESENTATIONS:

House Ways and Means Subcommittee, October 26, 1993. U.S. Health Care Reform: Implications for Patients, Practice and Progress, "How Quality Care Will Be Affected"; Beacon Hill Institute at Suffolk University and The Medical Action Committee for Education; Cambridge, Ma., November 13, 1993.

Winter Meeting of the National Governors' Association Health Networks Plenary Session, National Governors' Association, Washington, DC, January 31, 1994.

University of Texas School of Law Health Seminar, Austin, Texas, "Breast Cancer: Diagnostic Delay and Its Significance" January 1996.

American Association of Legal Nurse Consultants Greater Houston Chapter Annual Seminar, Houston, Texas, "Managed Care and Its Influence on Clinical Medicine," October 1996.

CNN Interview, Financial Report, August 5, 1997.

American Society of Dermatology, October 5, 1997.

Panelist, Cooper Institute for Advanced Studies in Medicine and the Humanities, Naples, FL. "Patient Relationship - A Dialogue: Understanding Managed Care". February 1998.

Host - "PWC Presents" on weekly cable TV. October 1998-

Nurse Oncology Educational Program, Laredo, Texas, January 15, 1999.

Independent Professional Medical Review Fee: $350.00 Per Hour

Dr. Cohen can be reached at Medical Office: Phone 210/590-8206
FAX: 210/590-8251

CLINICAL RESEARCH EXPERIENCE:

A Phase III, Double Blind, Placebo-controlled multicenter study to determine the effectiveness and tolerability of the combination of XXXXX and XXXXX Versus XXXXX in H.I.V.-1 Infected patients receiving XXXXX XXXXX (NRTI) Therapy.
Sponsor: Dupont Merck Pharmaceuticals Co.
Stephen Carl Cohen, MD: Sub-Investigator 1997-1999

A Randomized Double Blind Placebo Controlled Comparison of the Analgesic Activity of XXXXX BID as Add-On-Therapy to Opioid Medication in Patients with Chronic Cancer Pain
Sponsor: Searle
Stephen Carl Cohen, MD: Principal Investigator 1998-2000

A Randomized, Double-Blind, Active-Comparator-Controlled, Parallel-Group Study to Evaluate the Safety of XXXXX in Patients with Osteoarthritis or Rheumatoid Arthritis
Sponsor: Merck
Stephen Carl Cohen, MD: Principal Investigator 2003-2006

A 6-Month Double-blind, Double-dummy, Randomized, Parallel group, Multicenter Efficacy and Safety Study of XXXXX Compared to XXXXX, XXXXX and Placebo in Patients with COPD
Sponsor: AstraZeneca
Stephen Carl Cohen, MD: Principal Investigator 2003-2006

A Study To Evaluate The Clinical And Microbial Efficacy And Safety Of XXXXX Compared To Vehicle In The Treatment Of Bacterial Conjunctivitis

Sponsor: Insite Vision Inc.
Stephen Carl Cohen, MD: Sub-Investigator 2004-2005

A Phase I Open-Label Escalation Study of XXXXX Injection Administered Intratumorally and Locally to Patients with Solid Tumors In accordance with Sponsors protocol no. XXXXX
Sponsor-CRO: PPD Development
Stephen C. Cohen, M.D. Medical Monitor

A Randomized, 24-week, Double-blind, Placebo-controlled, Parallel-group Study to Evaluate the Efficacy, Safety and Tolerability of XXXXX in Patients with Chronic Obstructive Pulmonary Disease (COPD)
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2004-2006

A Randomized, Investigator-Blind, Active-Controlled, Parallel-Group Study To Compare The Efficacy And Safety Of 6-Week Treatment With XXXXX Pediatric Suspension In Children With Tinea Capitis
Sponsor: Novartis
Stephen Carl Cohen, MD: Principal Investigator 2004-2006

A Multicenter, Double-Blind, Placebo-Controlled Efficacy and Safety Study of XXXXX in Female Patients with Irritable Bowel Syndrome
Sponsor: Pain Therapeutics, Inc.
Stephen Carl Cohen, MD: Sub-Investigator 2005-2006

A Multicenter, Double-Blind, Placebo-Controlled Efficacy and Safety Study of Low-Dose XXXXX in Male Patients with Irritable Bowel Syndrome
Sponsor: Pain Therapeutics, Inc.
Stephen Carl Cohen, MD: Sub-Investigator 2005-2006

An International, Randomized, Double-Blind, Placebo-Controlled, Multicenter, 6-Month Study Of The Efficacy And Safety Of XXXXX Vs. Placebo For The Suppression Of XXXXX Genital Herpes In Newly Infected Immunocompetent Subjects.
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2005-2006

An open-label, randomized, multicenter, clinical study to compare the effects XXXXX XXXXX, and XXXXX XXXXX on the penicillin or macrolide resistance of Streptococcus pneumoniae in patients with acute exacerbation of chronic bronchitis
Sponsor: Aventis
Stephen Carl Cohen, MD: Principal Investigator 2005

A Randomized, Double-Blind, Placebo-Controlled, Multicenter Phase 3 Study to Evaluate the Efficacy and Safety of XXXXX 1.5 mg Once Daily and 0.5mg Twice Daily for 12 Weeks for the Treatment of Opioid-Induced Bowel Dysfunction in Adults taking Opioid Therapy for Persistent Non-Cancer Pain
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2005-2006

A Multicenter, Randomized, Double-Blind, Triple-Dummy, Placebo-Controlled, Parallel Group, Four-Week Study Assessing the Efficacy XXXXX Nasal Spray 200 mcg QD versus XXXXX 10 mg QD in Adolescent and Adult Subjects with Asthma and Seasonal Allergic Rhinitis Who are Receiving XXXXX XXXXX 100/50 mcg BID or Placebo BID, Subject Activity
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2005-2006

Randomized, Double-Blind Trial of XXXXX 350-mg and 250 mg Tablet Compared to Placebo in Patients with Acute, Painful Musculoskeletal Spasm of the Lower Back
Sponsor: MedPointe Pharmaceuticals
Stephen Carl Cohen, MD: Principal Investigator 2005-2006

A phase III pivotal, multi-center, double-blind, randomized, placebo-controlled mono-therapy study of XXXXX for treatment of fibromyalgia
Sponsor: Forest Labs

Stephen Carl Cohen, MD: Principal Investigator 2005-2006

An extension phase III pivotal, multi-center, double-blind, randomized, placebo-controlled mono-therapy study of XXXXX for treatment of fibromyalgia
Sponsor: Forest Labs
Stephen Carl Cohen, MD: Principal Investigator 2005-2006

Randomized, double-blind trial of XXXXX 250-mg tablets compared to placebo in patient with acute, painful musculoskeletal spasm of the lower back
Sponsor: MedPointe Pharmaceuticals
Stephen Carl Cohen, MD: Principal Investigator 2006

A multicenter, randomized, double-blind, prospective study comparing the safety and efficacy XXXXX and XXXXX combination therapy to XXXXX and XXXXX in subjects with mixed dyslipidemia
Sponsor: Abbott Labs
Stephen Carl Cohen, MD: Principal Investigator 2006

A phase IIIb Multicenter, randomized, double-blind, placebo-controlled study of XXXXX in subjects with moderate to severe persistent asthma who are inadequately controlled with high-dose XXXXX and long-acting XXXXX
Sponsor: Genentech
Stephen Carl Cohen, MD: Principal Investigator 2006

A 12- week, randomized, double-blind, dose-ranging, placebo-controlled study of XXXXX in subjects with irritable bowel syndrome
Sponsor: RTI
Stephen Carl Cohen, MD: Principal Investigator 2006

A clinical study to evaluate the safety and efficacy of XXXXX 12-HR 5 mg XXXXX tabled BID vs. placebo tablet in the treatment of Allergic Rhinitis
Sponsor: Schering Plough
Stephen Carl Cohen, MD: Principal Investigator 2006

A multicenter, randomized, double-blind, placebo-controlled, parallel group, adaptive-design, efficacy, safety and tolerability study of 4 fixed oral doses of XXXXX in adult outpatients with fibromyalgia syndrome
Sponsor: Wyeth
Stephen Carl Cohen, MD: Principal Investigator 2006

An observational study to characterize the burden of illness associated with laxative use in subjects using opioids for the management of persistent pain
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2006

A Long-Term Safety and Efficacy Study of XXXXX in Elderly Subjects with Primary Chronic Insomnia
Sponsor: Sepracor
Stephen Carl Cohen, MD: Principal Investigator 2006

A Multicenter, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group Study of Oral XXXXX for the Treatment of Opioid-induced Bowel Dysfunction in Subjects With Chronic Non-Malignant Pain
Sponsor: Wyeth
Stephen Carl Cohen, MD: Principal Investigator 2006

A Comparison of XXXXX Nasal Spray versus Oral XXXXX in the Treatment of Seasonal Allergic Rhinitis
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2006

A Multi-Center, No Drug Treatment, Cross-Sectional Survey Study to Develop and Validate the Rhinitis Control Assessment Questionnaire (RCAQ) in Adult and Adolescent Subjects 12 Years of Age and Older with Non-Infectious Allergic Rhinitis
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2006

Evaluation of nasal congestion clinical efficacy for XXXXX 25 mg and XXXXX 50 mg in seasonal allergic rhinitis: A randomized, double-blind, placebo and XXXXX controlled study
Sponsor: Pfizer
Stephen Carl Cohen, MD: Principal Investigator 2006

A 12-week, randomized, double-masked, parallel group comparison of XXXXX given in the evening, XXXXX given in the evening, and XXXXX given in the morning in subjects with open angle glaucoma or ocular hypertension in the United States
Sponsor: Pfizer
Stephen Carl Cohen, MD: Sub-Investigator 2006

A double-blind, placebo controlled evaluation of the efficacy, safety and tolerability of XXXXX in the treatment of breakthrough pain in cancer patients
Sponsor: BSI
Stephen Carl Cohen, MD: Principal Investigator 2006

An open label, long-term treatment evaluation of safety of XXXXX use for breakthrough pain in cancer subjects on chronic opioid therapy
Sponsor: BSI
Stephen Carl Cohen, MD: Principal Investigator 2006

A study to evaluate the clinical and microbial efficacy of XXXXX compared to vehicle in the treatment of bacterial conjunctivitis, Pediatric ages 6 months to 18years old
Sponsor: Bausch & Lomb
Stephen Carl Cohen, MD: Sub-Investigator 2006

A 6-Month Open-Label Extension Study of the Long-Term Safety of XXXX in Outpatient with Fibromyalgia Syndrome
Sponsor: Wyeth
Stephen Carl Cohen, MD: Principal Investigator 2006

A 52-week Randomized, Double-Blind, Parallel Group, Placebo Controlled, Multicenter Clinical Trail, To Assess The Efficacy and Safety of 200mg of the XXXXX Compared to Placebo, Both Administered Once Daily By Inhalation, in the maintenance treatment of patients with moderate to severe, stable chronic obstructive pulmonary disease
Sponsor: Almirall Prodesfarma
Stephen Carl Cohen, MD: Principal Investigator 2006

Randomized, Double-Blind Trial of the Combination of XXXXX 250-mg Tablets and XXXXX 50-mg Tablets Compared to Placebo and Either Product Alone in Patients with Acute, Painful Musculoskeletal Spasm of the Lower Back
Sponsor: Medpointe
Stephen Carl Cohen, MD: Principal Investigator 2007

A Randomized, Double-Blind, Placebo Controlled, Safety and Efficacy Study of XXXXX in Subjects with Fibromyalgia
Sponsor: Jazz Pharmaceuticals, Inc.
Stephen Carl Cohen, MD: Principal Investigator 2007

A Long-Term, Open Label Safety and Efficacy Study of XXXXX in Subjects with Fibromyalgia
Sponsor: Jazz Pharmaceuticals, Inc.
Stephen Carl Cohen, MD: Principal Investigator 2007

A randomized, open-label, blinded-endpoint, parallel-group trial of GI safety of XXXXX compared with non-selective XXXXX in osteoarthritis patients
Sponsor: Pfizer
Stephen Carl Cohen, MD: Principal Investigator 2007

A 16-week, Parallel-Group, Double-Blind, Randomized, Placebo-Controlled, Multicenter, Dose-Ranging Study to Evaluate the Efficacy, Safety and Tolerability of Multiple Doses and Multiple treatment Regimens of XXXXX, with XXXXX as an Open-Label Active Reference, in Subjects with Type 2 Diabetes Mellitus
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2007

A 12-Week, Multicenter, Randomized, Double-Blind, Parallel-Group Study of the Combination of XXXXX and XXXXX Compared to XXXXX and XXXXX in Subjects with Type IIa and IIb Dyslipidemia
Sponsor: Abbott Laboratories
Stephen Carl Cohen, MD: Principal Investigator 2007

A Randomized, Open-Label, Two-Way Crossover Trial of XXXXX Inhalation Solution (20mcg) and XXXXX in the Treatment of Patients with Chronic Obstructive Pulmonary Disease
Sponsor: Dey
Stephen Carl Cohen, MD: Principal Investigator 2007

A Double-Blind, Randomized, Placebo-Controlled Phase 2b Study of XXXXX, XXXXX, and XXXXX mg BID XXXXX in Female Outpatients with Irritable Bowel Syndrome
Sponsor: Pharmos

Stephen Carl Cohen, MD: Principal Investigator 2007

Safety and Efficacy of Olopatadine HCI Nasal Spray in 6-11 Year Old Patients
Sponsor: Alcon
Stephen Carl Cohen, MD: Sub-Investigator 2007

A Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Multi-Center Study to Evaluate the Effects of a One-Year Course of XXXXX XXXXX Nasal Spray XXXXX QD on Growth in Pre-Pubescent, Pediatric Subjects with Perennial Allergic Rhinitis.
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2007

A Multi-center, Randomized, Controlled Study to Investigate the Safety and Tolerability of XXXXX XXXXX (XXXXX) vs. Standard Medical Care in Treating Iron Deficiency Anemia in Heavy Uterine Bleeding and Postpartum Patients
Sponsor: Luitpold Pharmaceuticals
Stephen Carl Cohen, MD: Principal Investigator 2007

A Randomized, Double-Blind, Placebo-Controlled, Multicenter, Parallel Group Study to Assess the Efficacy (Reduction of Cardiovascular Disease Events) and Safety of 100 mg XXXXX XXXXX XXXXX in Patients at Moderate Risk of Cardiovascular Disease
Sponsor: Bayer Healthcare
Stephen Carl Cohen, MD: Principal Investigator 2007

A Randomized, Double-Blind, Placebo and Active Comparator-Controlled, Parallel-Group Study of the Efficacy and Safety of XXXXX as Monotherapy Treatment of Type 2 Diabetes Mellitus
Sponsor: Daiichi Sankyo Development
Stephen Carl Cohen, MD: Principal Investigator 2007

A randomized, multicenter, double-blind study to compare the efficacy of single-day treatment (1000 mg b.i.d.) with XXXXX compared to that of Placebo in patient-initiated episodic treatment of recurrent genital herpes in immunocompetent black patients
Sponsor: Novartis
Stephen Carl Cohen, MD: Principal Investigator 2007

A Phase 3 Multicenter, Randomized, Double-Blind, Placebo-Controlled Study to Evaluate the Efficacy and Safety of XXXXX XXXXX in Subjects with Uncomplicated Acute Influenza
Sponsor: Biocryst
Stephen Carl Cohen, MD: Principal Investigator 2007

A Multi-center, Randomized, Double-blind, Placebo-controlled Study with an Open-label Run-in to Assess the Efficacy, Tolerability, and Safety of XXXXX 10 or XXXXX 20 Compared to Placebo in Opioid-naïve Subjects with Moderate to Severe, Chronic Low Back Pain
Sponsor: Purdue Pharma, L.P.
Stephen Carl Cohen, MD: Principal Investigator 2007

A Multi-center, Randomized, Double-blind, Placebo-controlled Study with an Open-label Run-in to Assess the Efficacy, Tolerability, and Safety of XXXXX 10 or XXXXXX 20 Compared to Placebo in Opioid-naïve Subjects with Moderate to Severe, Chronic Pain due to Osteoarthritis of the Knee.
Sponsor: Purdue Pharma, L.P.
Stephen Carl Cohen, MD: Principal Investigator 2007

A Phase II randomized, observer blind, multicenter study of XXXXX XXXXX combined XXXXX XXXXX XXXXX XXXXX (XXXX) versus XXXXX, according to a one dose schedule, both administered subcutaneously at 12-14 months of age, concomitantly with XXXXX XXXXX XXXXX (XXXXX) and XXXXX XXXXX XXXXX (XXX) but at separate sites.
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Sub-Investigator 2007

The Efficacy and Safety of XXXXX in the Treatment of Osteoarthritis of the Knee
Sponsor: Wyeth
Stephen Carl Cohen, MD: Principal Investigator 2007

Efficacy and Safety of 200 mcg BID XXXXX Nasal Spray (XXXX) vs Placebo as Adjunctive Treatment to Antibiotics in Relief of Symptoms of Acute Bacterial Sinusitis
Sponsor: Schering-Plough
Stephen Carl Cohen, MD: Principal Investigator 2007
A multi-center, randomized, double-blind, placebo-controlled, parallel-group study evaluating the efficacy and impact on health-related quality of life of XXXXX 5 mg once daily given for 2 weeks in subjects 18 yr of age and older with seasonal allergic rhinitis
Sponsor: UCB Inc.
Stephen Carl Cohen, MD: Principal Investigator 2008

A Multiple-Dose, Non-Randomized, Open-Label, Multicenter Study to Evaluate the Long-Term Safety and Effectiveness of XXXXX in the Treatment of Breakthrough Pain in Cancer Patients
Sponsor: Endo Pharmaceuticals
Stephen Carl Cohen, MD: Principal Investigator 2008

Evaluation of XXXXX XXXXX (XXXXX) on Carotid Intima-Media Thickness (cIMT) in Subjects with Type IIb Dyslipidemia with Residual Risk in Addition to XXXXX XXXXX (XXXXX) Trial
Sponsor: Abbott Laboratories
Stephen Carl Cohen, MD: Principal Investigator 2008

A Randomized, Double-blind, Placebo-controlled Study of XXXXX (XXXXX) in the Treatment of Irritable Bowel Syndrome with Diarrhea (IBS-D)
Sponsor: AGI Therapeutics
Stephen Carl Cohen, MD: Principal Investigator 2008

An Open-label, Roll-over Safety Study of XXXXX (XXXXX) in the Treatment of Irritable Bowel Syndrome with Diarrhea (IBS-D)
Sponsor: AGI Therapeutics
Stephen Carl Cohen, MD: Principal Investigator 2008

Randomized, Double-Blind, Double-Dummy Trial of Two Sustained Release Formulations of XXXXX Compared to Placebo in Patients with Acute, Painful Musculoskeletal Spasm of the Lower Back
Sponsor: Meda Pharmaceuticals
Stephen Carl Cohen, MD: Principal Investigator 2008

A 12-week, randomized, double-blind, double dummy, multi-center, phase IV study comparing the efficacy and safety of XXXX XXXXX XXXX x 2 actuations twice daily versus XXXXX XXXXX XXXXX XXXXX XXXXX x 2 inhalations twice daily, in adult and adolescent (≥12 years) African American subjects with asthma
Sponsor: AstraZeneca
Stephen Carl Cohen, MD: Principal Investigator 2008

A Randomized, Double-Blind, Placebo-Controlled, Safety and Efficacy Study of XXXXX (XXXXX XXXXX) in Subjects with Fibromyalgia
Sponsor: Jazz Pharmaceuticals
Stephen Carl Cohen, MD: Principal Investigator 2008

A Multicenter, Randomized, Double-Blind, Placebo Controlled, XXXXX-Referenced, Parallel-Group, Adaptive Design Study of XXXXX XXXXX in Adult Female Outpatients With Fibromyalgia Syndrome
Sponsor: Wyeth Consumer Healthcare
Stephen Carl Cohen, MD: Principal Investigator 2008

A Multicenter, Randomized, Double-Blind Study to Evaluate the Efficacy and Safety of XXXXX Compared to XXXXX in Elderly Subjects with Type 2 Diabetes
Sponsor: Takeda Global Research & Development
Stephen Carl Cohen, MD: Principal Investigator 2008

A Multi-center, Randomized, Controlled Study to Investigate the Safety and Tolerability of A Single Dose of XXXXX XXXXX XXXXX (XXXXX) vs. Standard Medical Care in Treating Iron Deficiency Anemia in Subjects Who are Not Dialysis Dependent

Sponsor: Luitpold Pharmaceuticals, Inc.

Stephen Carl Cohen, MD: Principal Investigator 2008

A Randomized, Double-Blind, Multicenter Trial Comparing the Efficacy of the
XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX (XXXXX) to a Control for the Treatment of Chronic Lower Back Pain
Sponsor: Empi, a ReAble Company
Stephen Carl Cohen, MD: Principal Investigator 2008

A Randomized, Multiple-Dose, Double-Blind, Crossover Trial to Assess the Systemic Exposure of XXXXX XXXXX (XXXXX)/XXXXX XXXXX (XXXXX) Fixed-Dose Combination Compared to XXXXX and XXXXX Monocomponents, and a 7-Day Open-Label Extension in Subjects with Chronic Obstructive Pulmonary Disease (COPD)
Sponsor: Dey, LP
Stephen Carl Cohen, MD: Principal Investigator 2008

A multicenter, randomized, placebo-controlled, "factorial" design, 12-month study to evaluate the efficacy and safety of XXXXX 25 mg/day and 50 mg/day co-administered with all registered XXXXX strengths ranging from 10 mg to 80 mg in patients with primary hypercholesterolemia
Sponsor: Sanofi Aventis
Stephen Carl Cohen, MD: Principal Investigator 2008

A Randomized, Double-blind, Placebo-controlled Study to Evaluate the Safety and Tolerability of XXXXX in Subjects with Acute Back Spasms
Sponsor: Xenoport
Stephen Carl Cohen, MD: Principal Investigator 2008

Safety and Tolerability Study Comparing XXXXX XXXXX Given as an Oral solution to a Single-blinded Combination of Oral Tablets plus Oral Solution in Subjects with Fibromyalgia
Sponsor: Jazz Pharmaceuticals
Stephen Carl Cohen, MD: Principal Investigator 2008

Randomized, Double-Blind, Double-Dummy Trial of Two Sustained Release Formulations of XXXXX Compared to Placebo in Patients with Acute, Painful Musculoskeletal Spasm of the Lower Back

Sponsor: Meda Pharmaceuticals
Stephen Carl Cohen, MD: Principal Investigator 2008

A Double Blind Placebo Study to Determine the Effectiveness of XXXXX on the Management of Chronic Back Pain

Sponsor: Targeted Medical Pharma, Inc.
Stephen Carl Cohen, MD: Principal Investigator 2009

An 8-Week, Multicenter, Randomized, Double-blind, Four-arm, Parallel-group Study Comparing the Safety and Efficacy of XXXXX to XXXXX in Subjects with Hypercholesterolemia
Sponsor: Abbott Laboratories
Stephen Carl Cohen, MD: Principal Investigator 2009

A Randomized, Double-Blind, Placebo- and Active-Controlled, Parallel-Group, Multicenter Study to Determine the Efficacy and Safety of XXXXX When used in Combination With XXXXX Compared with XXXXX Plus XXXXX, XXXXX Plus XXXXX, and XXXXX Plus Placebo in Subjects With Type 2 Diabetes Mellitus
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2009

A Randomized, Open-Label, Parallel-Group, Multicenter Study to Determine the Efficacy and Long Term Safety of XXXXX Compared With XXXXX in Subjects With Type 2 Diabetes Mellitus
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2009

A Randomized, Double-Blind, Placebo- and Active-Controlled, Parallel-Group, Multicenter Study to Determine the Efficacy and Safety of XXXXX Administered in Combination With XXXXX and XXXXX Compared With XXXXX Plus XXXXX and Placebo and With XXXXX Plus XXXXX and XXXXX in Subjects With Type 2 Diabetes Mellitus
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2009

A Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Multicenter Study to Determine the Efficacy and Safety of XXXXX When Used in Combination With XXXXX With or Without XXXXX in Subjects with Type 2 Diabetes Mellitus
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2009A Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Multicenter Study to Determine the Efficacy and Safety of Two Dose Levels of XXXXX Compared With Placebo in Subjects With Type 2 Diabetes Mellitus
Sponsor: GlaxoSmithKline
Stephen Carl Cohen, MD: Principal Investigator 2009

A Randomized Double-Blind Parallel Study of XXXXX Extended-Release 50 mg Versus XXXXX 40 mg for Healing and Symptomatic Relief of Moderate to Severe Erosive Gastroesophageal Reflux Disease (GERD)
Sponsor: Eisai
Stephen Carl Cohen, MD: Principal Investigator 2009

A Phase 3, Double-Blind, Randomized, Factorial, Efficacy and Safety Study of XXXXX Plus XXXXX Fixed-Dose Combination in Subjects with Moderate to Severe Hypertension
Sponsor: Takeda Global Research and Development Inc.

Stephen Carl Cohen, MD: Principal Investigator 2009

A Randomized, Double Blind, Active Controlled Crossover Study to Evaluate the Efficacy and Safety of XXXXX XXXXX Tablets Compared With Immediate Release XXXXX for the Management of Breakthrough Pain in Opioid Tolerant Patients With Chronic Pain, Followed by a 12 Week Open Label Extension to Evaluate the Impact of XXXXX XXXXX Tablets on Patient Outcomes
Sponsor: Cephalon
Stephen Carl Cohen, MD: Principal Investigator 2009

An Open-Label Study to Evaluate the Long-term Safety of Subcutaneous XXXXX for Treatment of Opioid-Induced Constipation in Subjects With Nonmalignant Pain
Sponsor: Wyeth Research
Stephen Carl Cohen, MD: Principal Investigator 2009

A Prospective, Randomized, Double Blind Study of the Efficacy of XXXXX in Atopic Asthmatics With Good Lung Capacity Who Remain Difficult To Treat (EXACT)
Sponsor: Genentech
Stephen Carl Cohen, MD: Principal Investigator 2009

A Phase II, Randomized, Double-Blind, Placebo-Controlled Study to Evaluate the Safety, Tolerability and Efficacy of XXXXX (XXXXX) in Adult Patients with Asthma Who Are Inadequately Controlled on Inhaled Corticosteroids (MILLY)

Sponsor: Genentech, Inc.

Stephen Carl Cohen, MD: Principal Investigator 2009

A Multi-Center Phase III Study to Evaluate XXXXX, a Novel XXXXX Gel 0.5% Formulation, for the Control of Head Lice in Pediatric Subjects and Adult Subjects with Pediculosis Capitis
Sponsor: TARO Pharmaceuticals USA, Inc.
Stephen Carl Cohen, MD: Principal Investigator 2009

A Phase 3 Randomized, Double-Blind, Placebo-Controlled Multicenter Study of XXXXX on Peripheral Nerve Function in Patients with Osteoarthritis
Sponsor: Pfizer, Inc.
Stephen Carl Cohen, MD: Principal Investigator 2009

A 26-week, multinational, multi-centre, open-labelled, two-arm, parallel, randomised, treat-to-target trial comparing efficacy and safety of XXXXX (XXXXX) once daily plus meal-time insulin aspart for the remaining meals vs. basal-bolus treatment with insulin detemir plus meal-time insulin aspart in subjects with type 1 diabetes.
Sponsor: Novo Nordisk
Stephen Carl Cohen, MD: Principal Investigator 2009

A 52-week randomised, controlled, open label, multicentre, multinational treat-to-target trial comparing the efficacy and safety of XXXXX and insulin glargine, both injected once daily in combination with oral anti-diabetic drugs (OAD), in subjects with type 2 diabetes mellitus currently treated with OAD(s) and qualifying for more intensified treatment

Sponsor: Novo Nordisk
Stephen Carl Cohen, MD: Principal Investigator 2009

A Dose-Response Efficacy and Safety Study of XXXXX XXXXX (XXXXX) as Adjunctive Therapy in Subjects with Gastroesophageal Reflux Disease (GERD) who are Incomplete Responders to a Proton Pump Inhibitor (PPI)
Sponsor: Xenoport
Stephen Carl Cohen, MD: Principal Investigator 2009

A Multicenter, Randomized, Double-Blind, Placebo-Controlled Study to Evaluate Cardiovascular Outcomes Following Treatment with XXXXX in Addition to Standard of Care in Subjects with Type 2 Diabetes and Acute Coronary Syndrome

Sponsor: Takeda
Stephen Carl Cohen, MD: Principal Investigator 2009

A Multicenter, Randomized, Double - Blind, Placebo-Controlled Study to Determine the Efficacy and Safety of Alogliptin Plus Metformin, Alogliptin Alone, or Metformin Alone in Subjects with Type 2 Diabetes.
Sponsor: Takeda
Principle Investigator: Stephen C. Cohen, M.D. 2010

A study comparing powered Bone Marrow Biopsy Procedures tp Manual Bone Marrow Biposy procedures using healthy volunteers
Sponsor: Vidacare Corporation
Primary Investigator: Larry Miller, M.D.
Back Up Investigator: Stephen C. Cohen M.D. 2010

A Phase 2, Randomized, Double-Blind, Placebo Controlled, Multicenter Study Evaluating the Efficacy and Safety of Two Doses of favipiravir in Adult Patients with Uncomplicated Influenza.
Sponsor: Toyama Chemical Co Ltd
Principle Investigator: Stephen C. Cohen. M.D. 2011

A randomized, double-blind, placebo-controlled multi center study of BYM338 for treatment of
of cachexia in patients with Stage-IV non-small cell lung carcinoma or Stage III/IV adeno carcinoma of the pancreas.
Sponsor: Novartis
Principle Investigator: Stephen C. Cohen, M.D. 2011

A Phase II, Randomized, Double Blind, Placebo controlled, multicenter Study to Investigate the Impact of NPR in Subjects with Insurable Pain due to Malignancy.
Sponsor: Diamyd
Principle Investigator: Stephen C. Cohen, M.D. 2011

A Randomized open labeled, multicenter phase III Study of Efficacy and Safety in Polycythemia vera subjects who are resistant to or intolerant of hydroxyurea; JAK inhibitor INC424 tablets vesus best available care (The Response Trial)
Sponsor: Novartis
Principle Investigator: Stephen C. Cohen, M.D. 2011

A Phase 2, Randomized, Double-Blind, Placebo Controlled, Multicenter Study Evaluating the Efficacy and Safety of Two Doses of favipiravir in Adult Patients with Uncomplicated Influenza.
Sponsor: Toyama Chemical Co Ltd
Principle Investigator: Stephen C. Cohen. M.D. 2012

Study title: A Study Comparing Powered Ported Bone Marrow Aspiration Procedures to Manual Standard Bone Marrow Aspiration Procedures Using Healthy Volunteers (2014-12)

Participated as a co-principal investigator for the above-referenced study in which healthy volunteers underwent bilateral bone marrow aspiration of the posterior iliac crest for comparative pathological analysis of bone marrow specimens collected with the standard manual bone marrow aspiration device and with the OnControl Bone Marrow Ported Aspiration System.

Dates involved: October 2014- December 2014

Sponsor: Vidacare LLC, a division of Teleflex Incorporated

Exhibit B.

Thelma Watts Reynold's deposition transcript dated March 15, 2019.

CAUSE NO. 2018-CI-13942

THELMA LOUISE REYNOLDS,	§	IN THE DISTRICT COURT
	§	
Plaintiff,	§	
	§	
vs.	§	
	§	BEXAR COUNTY, TEXAS
	§	
JAYASREE RAO, M.D. and	§	
ONCOLOGY SAN ANTONIO	§	
CANCER CENTER NETWORK,	§	
	§	
Defendants.	§	45TH JUDICIAL DISTRICT

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ORAL AND VIDEOTAPED DEPOSITION
OF
THELMA LOUISE REYNOLDS

MARCH 15, 2019

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ORAL and VIDEOTAPED DEPOSITION OF THELMA LOUISE REYNOLDS, produced as a witness at the instance of Plaintiff's counsel, and duly sworn, was taken in the above-styled and numbered cause on March 15, 2019, from 9:52 a.m. to 10:39 a.m., before Deborah A. Koole certified Shorthand Reporter in and for the State of Texas, reported by computerized stenotype machine at Heritage Creek Assisted Living, 6538 Eckhert Road, San Antonio, Bexar County, Texas, pursuant to the Texas Rules of Civil Procedure and the provisions stated on the record or attached hereto.

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ALSO PRESENT:

Mr. Garland Lyle Reynolds

Ms. Deborah A. Koole, CSR

Mr. Pete Resendez, Videographer

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NO EXHIBITS MARKED.

THE VIDEOGRAPHER: This marks the start of the Thelma Louise Reynolds deposition. Today is Friday, March 15, 2019. The time on record is 9:52.

THELMA LOUISE REYNOLDS,
having been first duly sworn through the interpreter, testified as follows:

* * * * *

EXAMINATION BY MR. POWELL:

Q. Would you please tell us your full name.

A. Thelma Louise Watts Reynolds.

Q. All right, Mrs. Reynolds. And do you understand that your testimony is being videotaped today to show to the jury?

A. Yes.

Q. And you understand that it's being typed out by the court reporter who's here to your left?

A. Yes.

Q. And we're taking this deposition in your room at the assisted living center?

A. Yes.

Q. Okay. Tell the jury where you were born.

A. I was born in San Antonio, Texas.

Q. All right. What hospital?

A. Santa Rosa Hospital.

Q. And how old are you now?

A. Eighty-four.

Q. All right. And where did you grow up?

A. San Antonio.

Q. And where did you graduate from high school?

A. I graduated from Brackenridge High School in 1952.

Q. Now, we have your husband Lyle sitting at the back of the room. How long have you and Lyle been married for?

A. Sixty-four years in March it was.

Q. All right, wonderful. You want to tell the jury the secret of a long marriage.

A. Well, we -- when we married, there were -- there were three of us -- Lyle, me, and the Lord, our Lord.

Q. And that's helped you throughout your 64 years of March?

A. Through the whole, yes, many times.

Q. All right. Now, you and Lyle have children. What are their names?

A. David -- David Lyle Reynolds and Susan Louise Reynolds.

Q. All right. And you've got seven grandchildren. So, can you name them for the jury?

A. Can I name them?

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Q. Yep.
A. Let's see. Matthew, Michael, Eric.
Now let me go to Susan's. Robert, Chase and Elizabeth and Alexandra.
Q. Very good. And so, that's one husband, two children, seven grandchildren.
And do you have great-grandchildren?
A. We have two great-grandsons.
Q. And what are their names?
A. We have one on the way. What I mean is he will be adopted. Michael is not his father. Michael, my grandson, will be his father because he married JT's mother.
Q. Okay.
A. And so, he will eventually adopt JT and give him his name.
Q. All right. That's one great-grandchild. How about your second one?
A. Chase Hunter has a grandson with bright red hair, and his name is Ashton King.
Q. Okay. All right. Now, tell us about after high school. Where did you work?
A. I worked -- went to work at Security Service, which is a branch of the Air Force. And I also worked part-time at Joske's department store.

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Q. And what did you do at Security Service?
A. I was a typist.
Q. All right. Now, your husband Lyle, was he ever in the Air Force?
A. Yes, for four years.
Q. And then what did he do after that?
A. He began -- He worked for Security Service as a civilian.
Q. All right. And then did you stop working at Security Service at some point?
A. Well, when he retired.
Q. No, you. Okay.
He stopped -- He retired from Security Service?
A. Yeah.
Q. And then how about you; did you stop working at Security Service?
A. Yeah. I worked there three years.
Q. Okay.
A. And when I became pregnant, I quit working.
Q. Okay. And have you ever gone back to work after that?
A. Yes. At our day- -- At our church. I was the day-care director for 40 years.
Q. All right. And what church is that?

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A. That was -- It started at Southside Christian Church, and then I worked for Marbach Christian Church.
Q. All right. And then did you retire after that?
A. Yes.
Q. Okay.
A. I was in my 70s, so I decided it was --
Q. -- time to retire?
A. -- time to retire.
Q. All right. Now, you understand that your testimony today is being taken in a lawsuit where you have sued a Dr. Rao? Do you understand that?
A. Yes, yes.
Q. Now, what did you go see Dr. Rao for?
A. Lung cancer.
Q. And did any of your children go to your visits with Dr. Rao?
A. My daughter went most of the time.
Q. And this is Susan?
A. Yes.
Q. And did she stay out in the waiting room, or did she actually go in to the visits?
A. No, she went into the room with the doctor and me.
Q. Okay.

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A. And my son went a couple of times. But he lives in Fort Worth, so it was easier for Susan. She lived in Austin, so she would drive down here and take me.
Q. Now, if the lawyer for Dr. Rao wanted to know details about your visits with Dr. Rao, could he ask your daughter Susan about that?
A. She would probably know more than me.
Q. Okay. And did she also go with you to your visits to Dr. Conde?
A. Yes.
Q. Did she go with you to basically all of your doctors visits?
A. Basically, yes.
Q. And she went in to see the doctor with you; she just didn't stay out in the waiting room?
A. No. She went into the room with me and while I took -- had my blood tests taken and everything.
Q. Does she have any type of medical background or knowledge?
A. No. The only thing she did have, she rode with the -- the fire department.
MR. REYNOLDS: EMT.
A. And she learned a lot from them.
Q. (By Mr. Powell) Like as an EMT?

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A. Yes.
Q. Okay.
A. She learned to give shots.
Q. Now, when you went to see Dr. Rao, did she diagnose you with lung cancer?
A. No.
Q. Who diagnosed you with that?
A. Dr. Srinivasan.
Q. Okay. And then when you went to visit Dr. Rao, was she the one that was going to treat your lung cancer?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. Okay. And how did she explain to you that she was going to treat your lung cancer?
A. Well, she told me she's going to give me chemotherapy, which I figured that she would then. And I asked her if she was going to -- if I was going to have x-ray, you know, whatever you call that. And --
Q. Radiation?
A. Radiation. And she said, "Oh, no."
Q. Okay.
A. No.
Q. Now --

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A. And no surgery.
Q. No surgery. So, it was just going to be chemotherapy?
A. Yes.
Q. Did she explain to you about different types of chemotherapy that might be available?
A. I don't remember hearing any different types of chemotherapy. I thought there was just one.
Q. Okay. Did Dr. Rao discuss with you something called an ALK marker?
A. Uh-uh.
Q. Yes or no?
A. No.
Q. Okay. What did Dr. Rao tell you about your lung cancer? Was she expecting it to be fast-developing, slow-developing? What was your prognosis according to Dr. Rao?
A. She said it was a slow-growing cancer.
Q. Okay. Did she tell you that it was life-threatening then or that it was not life-threatening, or did she not say either way?
A. She didn't say either way.
Q. Okay. Now, did Dr. Rao then give you chemotherapy?
A. Yes.

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Q. And did Dr. Rao tell you any of the risks associated with chemotherapy?
A. Not that I remember.
Q. Were you given any paperwork about the risks?
A. Yes.
Q. Did you read over that paperwork?
A. I read over it, but I didn't understand it.
Q. Okay. Did Dr. Rao, or anybody at her office, go over that paperwork with you?
A. No.
Q. Did Dr. Rao, or anyone at the office -- at her office, explain to you the risks associated with the chemotherapy treatment?
A. No.
Q. Now, before you started the course of chemotherapy treatment, tell the jury about your health.
A. Well, my health was good. I was very thankful. I worked as many -- I worked sometimes ten hours a day at the church, with the children. And at wintertime or getting close to Christmas, I would bake dozens and dozens of cookies and fruitcake and a date loaf and pies because the kids always came to my house and -- for Christmas dinner and Thanksgiving dinner. And it was a glorious time. They would come over.

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Q. Now, before the chemotherapy treatment, were you able to sew?
A. Oh, yes. I sewed -- sewed forever. I love to sew. Right there by my sewing machine is a -- it's a quilt, about a yard long, that I made for -- they have a place here in town where you make quilts and donate them to -- they find children that need these quilts. I don't know the name of it, but I could get ahold of it on -- on my iPad, which I worked my iPad quite a bit, and my computer. I played the piano. And like I said, the sewing was the love of my life.
Q. Now, you also had a hobby of crocheting?
A. Crocheting, yes.
Q. And how does crochet differ from sewing?
A. You use yarn and you use needles, different needles.
Q. Okay.
A. And you work with your hands, and I can't do that anymore.
Q. Now, on -- What is the type of sewing machine that you have at your home?
A. At home I have a Singer sewing machine.
Q. Now, to use that machine, did that have one of those step pedals for your feet?
A. Yes. This one has the pedal, too.

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Q. Okay.
A. And it -- I bought this one at Sears. It's a portable.
Q. So, for you to sew, you needed to use your hands and your feet?
A. (Witness nods head up and down.)
Q. Right?
A. Right.
Q. Now, before the chemotherapy, did you need to use a walker to get around?
A. No.
Q. Did you need to use a wheelchair?
A. No.
Q. How easy was it for you to walk around and do things prior to the chemotherapy?
A. I was normal.
Q. Okay.
(Cell phone ringing.)
MR. POWELL: One second.
Q. (By Mr. Powell) So, prior to the chemotherapy, were you able to drive a car?
A. Yes. Oh, yes. I was able to drive my Lincoln that my husband bought for me.
Q. All right. What kind of car again? A Lincoln?

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A. A Lincoln.
Q. All right. And where did you drive to?
A. Well, I'd drive to the store. I'd drive to work, to the church a lot of the times.
Q. Were you able to do your own shopping?
A. Yes.
Q. Did you drive you and your husband around?
A. I did when he'd let me drive.
Q. Okay. He liked to drive when you two were together if he could?
A. Yes.
Q. How long could you drive? Like could you drive for 30 minutes? an hour? two hours? How long were you able to drive for?
A. Well, we have -- We have a condo down in Rockport, and we'd go down there every so often to fish. And that's a three-hour drive.
Q. And were you able to drive that yourself?
A. I was able to drive that and help him after he fell and broke his hip.
Q. Did you fish, also?
A. Did he fish?
Q. Did you fish?
A. Oh, yes.
Q. Were you a good fisherwoman?

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A. Yes, I was.
Q. Okay. Where did you fish? In the bay or deep sea or --
A. In the bay.
Q. And so, you cast your own reel and all that?
A. Yes, I did.
Q. Okay.
A. I could put the hook on there and everything.
Q. Right. And were you able to work around the house before the chemotherapy, cleaning up and cooking and that sort of thing?
A. Oh, yes.
Q. So --
A. I loved to do that. On rainy days -- rainy, cold days I would cook. I'd make a big pot of soup and maybe bake a pie or two. And -- I'd do that or either go into my sewing room -- I had my own sewing room -- and sew.
Q. So, before the chemotherapy you were able to live at your own home?
A. Oh, yes.
Q. And what's the address of your home?
A. 446 Creath, C-r-e-a-t-h.
Q. Okay.
A. It's on the south side.

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Q. Of San Antonio?
A. Yes.
Q. Now, today we're in an assisted living center.
A. Yes.
Q. And so, you're no longer able to live at your home address any further?
A. (Witness shakes head side to side.)
Q. Right?
A. Right.
Q. And why did you originally move to this assisted living center?
A. Because of the fact that I could no longer take care of my husband and he couldn't take care of me, and the chemotherapy just took away my life.
Q. Well, tell us about that. What did the chemotherapy do to you?
A. Well, my hands are no longer useful as far as crocheting or even sewing or even holding my great-grandbaby. I was afraid to hold him because my hands. And he -- I was afraid that I would drop him.
Q. Now, are --
A. My legs. My legs gave out. And she saw -- I'm sure she saw all this. And that is when -- because when I started -- when I started not walking right and

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not using my hands and I was complaining of that, that's when she let me go.
Q. Dr. Rao?
A. Yes. I haven't told you that before.
Q. Okay. Now --
A. But that's what happened. She -- Just one day I walked in, and she called me to her office and told me there was no more that she could do for me.
Q. All right.
MR. WOOLSEY: Objection; nonresponsive.
Q. (By Mr. Powell) Now, is that when you went to go see Dr. Conde?
A. No. We didn't go right away. My daughter and son were quite bothered by what happened, and it took them a while to get ahold of things. And, eventually, they decided that they wanted me to go to another doctor.
Q. Another cancer doctor or oncologist?
A. Yes.
Q. And that was Dr. Conde?
A. Yes.
Q. Before we talk about that, do you know what your diagnosis is for your hands and your feet, the problems in your hands and feet?
A. Well, it's chemothe- -- It's the chemotherapy

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that caused it.
Q. Right. And are you aware that you've been diagnosed with peripheral neuropathy in --
A. Yes.
Q. -- your hands and feet?
A. And I didn't know what that was.
Q. Okay. Well, what -- Now do you know what peripheral neuropathy is?
A. Yes.
Q. And te- --
A. I can't use my hands, and I can't walk right.
Q. All right. Well, tell the jury how your hands feel.
A. Well, they're tingly and they're like paralyzed.
Q. And tell the jury how your feet feel.
A. Well, they have minds of their own.
Q. Okay.
A. I have no control over them at times.
Q. Now, on some of your medical records it mentions something called "foot drop", that your foot was not staying in a normal position. Tell the jury how the neuropathy affected your ability to walk.
A. Well, they say I have a rolling ankle on my right foot. And when I try to stand up, my right foot

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just gives way and I can't stand up.
Q. All right. So, are you able to walk now without the help of a walker or a --
A. No.
Q. No. Are you able to walk with the help of a walker?
A. No.
Q. So, are you now wheelchair-bound?
A. Yes.
Q. And is the reason you're wheelchair-bound the peripheral neuropathy in your feet?
MR. WOOLSEY: Objection; leading.
A. Yes.
Q. (By Mr. Powell) Why are you wheelchair-bound?
A. Because of the neuropathy. I can't walk.
Q. Did Dr. Rao ever recommend you for hospice care?
A. That's what she did at the end --
Q. Did she --
A. -- when she told me there's nothing more she could do. And I think she told my daughter about the hospice.
Q. Do you know how long ago that was?
A. (Witness shakes head side to side.)

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Q. Did Dr. Rao ever tell you that you had less than six months to live?
A. No.
Q. Did she ever give you any prognosis as to how long you had to live?
A. No. I never asked her.
Q. Now, you said you went to go visit Dr. Conde?
A. (Witness nods head up and down.)
Q. Yes?
A. Right.
Q. And Dr. Conde did some testing. And did Dr. Conde ever tell you about this ALK marker? Do you remember ever any discussion about that?
A. No.
Q. Did Dr. Conde change the type of chemotherapy treatment that you had been given?
A. I'm not on chemotherapy.
Q. All right. Well, what did Dr. Conde do for you in terms of treatment?
A. She's giving me a pill.
Q. Do you know what that pill is?
A. No.
Q. Okay. Have you ever heard the medication Lyrica?
A. Yes.

Q. Have you been on Lyrica?
A. Yes.
Q. And what is that for? What does that treat?
A. Neuropathy.
Q. Does it help you, at all?
A. No.
Q. What are the side effects of it? Does it make you sleepy or anything like that?
A. Yes.
Q. Nauseous or anything?
A. No. It did at times make me nauseous, but they gave me a pill for nauseous.
Q. Okay. Has that pill helped with your nausea, at all?
A. Yes, it did help.
Q. Now, after the peripheral neuropathy set into your hands and your feet, were you able to sew?
A. Uh-uh.
Q. Why not?
A. Well, because of my hands. I sewed for a while, and then I had my stroke. But my hands -- My right hand caught up with my left hand as far as the neuropathy.
And they've tried to get me different cups to hold down in the lunchroom. And that's become

a problem -- eating and drinking. I can't hardly do that anymore. And I guess I'll have to let them feed me. Well, my husband has fed me a couple of times.
Q. So, are --
MR. WOOLSEY: Objection; nonresponsive.
Q. (By Mr. Powell) -- you able to use the sewing machine with your hands and the foot pedal with your foot now, or no?
A. No.
Q. Are you able to crochet?
A. (Witness shakes head side to side.)
Q. No or yes?
A. No.
Q. And why not?
A. Because my hands won't -- won't go -- won't go with the needles.
Q. Are you -- Are you able to clean up your room here by yourself?
A. Uh-uh.
Q. No?
A. (Witness shakes head side to side.)
And I used to love to clean my house. We had our own home. We still have our own home. And I loved to clean. I'd go room by room, and I used to love to clean up my room.

Q. And why can't you clean now?
A. Because of the neuropathy.
Q. How does it prevent you from cleaning?
A. Well, the family doesn't want me overdoing. And it's hard to use a sweeper or you -- or it's hard to mop or wax if you want to -- we had hardwood floors, and I would wax them maybe once a week. And then I wouldn't want Lyle to walk on them, but he'd walk on them anyway.
Q. Now, are you able to bake or cook today?
A. Well, not really because I'm not in my home. This is the place. And that's what it is, a place for me to be comfortable, but it's not my home.
Q. If you had your best wish, would you rather live at your home or at an assisted living center?
A. I would rather live at home, both of us would.
Q. But for the peripheral neuropathy in your hands and feet, do you think you would be able to live at home?
A. No.
MR. WOOLSEY: Objection; form.
Q. (By Mr. Powell) Why would you not be able to live at home?
A. Because I couldn't take care of myself.

Q. And is that from the peripheral neuropathy or something else?
A. Well, it's from neuropathy.
Q. Any other reason why you wouldn't be able to live at home other than the neuropathy?
A. No.
Q. So, you think you would be able to live at home if you did not have neuropathy?
A. (Witness nods head up and down.)
MR. WOOLSEY: Objection; leading.
Q. (By Mr. Powell) Yes?
A. Yes.
Q. Now, one question back to Dr. Conde. Did she give you a pill for your cancer that was not chemotherapy? Do you remember her giving you a pill?
A. Oh, yes.
Q. Okay.
A. I'd take two of them a day.
Q. All right. Has Dr. Conde given you a prognosis in terms of how long --
A. No. I haven't -- There, I haven't asked her.
Q. Okay.
A. She has told me that what she's doing will not make -- will not make the cancer go away.
Q. Okay.

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A. But she said it would prolong. She wants to prolong my life.
Q. And has she told you how long she thinks she can do that?
A. No.
Q. And you've not asked her?
A. No.
Q. But is it your understanding that the cancer is still slow-developing?
A. Yes. She's going to take a PET scan in a couple of weeks. A PET scan is better than any kind of scan or x-ray because the PET scan shows the cancer more or better than just regular x-rays. The PET -- It's a PET scan.
Q. Now, are you able to feel the cancer in your lungs?
A. No.
Q. Okay. And does the cancer in your lungs cause you any pain that you're aware of?
MR. WOOLSEY: Objection; form.
A. No.
Q. (By Mr. Powell) Now, have you seen any other doctors or are you seeing any other doctors besides Dr. Conde?
A. No.

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Q. Are you in hospice care now?
A. No.
Q. When did they take you off of hospice care, do you know?
A. Lyle is thinking.
Q. It's been a while, though?
A. Yes. And the reason why they took me off of hospice care was because when you're in hospice care, you're not supposed to see any more -- any doctors, any other doctors, and David and Susan wanted me to see another oncologist.
Q. Right.
MR. WOOLSEY: Objection; nonresponsive.
Q. (By Mr. Powell) So, you are getting care today from an oncologist to try to extend your life -- life expectancy, right, Dr. Conde?
A. Yes.
Q. And -- but you're -- And you're also getting physical therapy here at the assisted living center?
A. Yes.
Q. Who is your physical therapist?
A. Well, you met him. He was right there. Clint.
Q. Clint. And does he do exercises with you on your hands?

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A. Yes.
Q. What are those?
A. Well, he wants me to keep my -- This hand is swollen. This hand is swollen, and for some reason it's -- I guess it's poor circulation. I don't know, but it's swollen. And I haven't done anything to it. But he works my fingers and tells me to do exercises that will help or he hopes will help the chemotherapy.
Q. Okay. And how about your feet, do you do any exercises on your feet?
A. Yes, on my legs. I've got -- Right now, if you want to roll up my pants leg, I've got a new -- a new brace on my leg that they put on just the other day.
Q. All right. And has your physical therapist given you any prognosis? Like, does he expect you to be able to walk again, or did he say?
A. Well, they're hoping because -- they're just hoping, but so far I haven't been able to stand. And I mean you have to stand to be able to walk.
Q. Right. Now, you had a minor stroke a little while back. Could you tell the jury about that.
A. Well, I don't know when I had it or how I had it. I can't tell you. But one morning I was over at the other place, and they called my daughter and told

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her that I wasn't acting normal. I wasn't acting right.
So, she came over and she could see, too. And I told her no, I felt fine. I didn't want to go to the hospital. So, she took me to the hospital, and they prognosed me as having a stroke. So, that's when they sent me to the hospital.
Q. Okay. And you're doing very well today. You have a good recall of events, and you appear to be doing well, but what has been the consequences of the stroke? What -- How has that affected you?
A. Well, it affected mainly my left side is what it did. And my right side doesn't seem normal, but they told me that a stroke only affects one side.
Q. One side. Here, let me get that for you.
A. It doesn't affect two sides. It affects just one side.
Q. I'll give you that.
A. So --
MR. POWELL: Okay. Let me do this because I know we have limited time with you here today. And I want to give the other lawyer a chance to question you. So, if you don't mind, I'll pass it to you. I probably will have some further questions, but I do want to give you some time.

MR. WOOLSEY: Very good. I appreciate that.

MR. POWELL: So, now the lawyer for Dr. Rao is going to ask you some questions. Okay?

THE WITNESS: Okay.

* * * * *

EXAMINATION BY MR. WOOLSEY:

Q. Mrs. Reynolds, we met briefly before your deposition started. You understand -- I'm Bill Woolsey, and you understand that I represent Dr. Rao; correct?

A. Yes.

Q. And I hate that we have to meet under these circumstances, and I do only have a few questions to ask you thus far. And, particularly, I want to get a little bit of information about your health history prior to April of 2015. Okay?

And my understanding is that, in April of 2015, you went to the hospital due to diverticulitis. Does -- Do you recall that?

A. Yes.

Q. Okay. So, I want to use that date as kind of a marker in time and ask you what sort of health history you had prior to that. Any health conditions that you were dealing with before that date?

A. No, except for the -- what you just said.

Q. Okay. Did you ever have treatment for osteoporosis?

A. No.

Q. Or low bone density?

A. No.

Q. Okay. If there are medical records that reflect that, would those be simply erroneous or is it that maybe you're not recalling that treatment?

A. No. My sister now had what you've just said.

Q. Osteoporosis?

A. Yes.

Q. Okay. And did you have any treatment for that yourself?

A. No.

Q. Or testing conducted to determine whether you also had that condition?

A. Well, my mother might have had me tested -- I can't remember that far back -- because my sister had a bump -- a lump on her back. And so, my parents had her tested for that, and that's when they found out she had what you just said.

Q. Okay.

A. Now, she -- My mother might have had me tested, and by brother both, to see if we were clear of that.

Q. All right.

A. Because it was really upsetting for her -- to her for my sister to have it because they -- of course, she was told about how her back would de- -- be deformed. And, eventually, Maxine was told, if she didn't have surgery on her back, she could have paralysis and end up in a wheelchair.

Q. Okay. Thank you, ma'am. I appreciate that. Let me -- Let me ask you just a couple of general questions.

Your daughter's name is Susan?

A. Yes.

Q. Where does Susan live?

A. She lives here now.

Q. Here being San Antonio?

A. Yes.

Q. And Susan's full name is what, please?

A. Susan what?

Q. What's her full name, last name?

A. Susan Louise Downey, but it will be -- she's using Reynolds again because she divorced her husband.

Q. Okay. And although they have divorced, can you tell me what her ex-husband or soon-to-be ex-husband's name is if you know it?

A. Bob, Robert.

Q. Downey?

A. Robert Downey.

Q. Thank you, ma'am.

And your son, what's his full name? I assume he goes by Reynolds.

A. David Lyle.

Q. David Lyle Reynolds?

A. (Witness nods head up and down.)

Q. And does -- Does David Lyle Reynolds live in San Antonio?

A. No. He lives in Bedford. He works --

Q. Up near Dallas?

A. Yes. He works for Bell Helicopter and has for 40 -- over 40 years.

Q. Excellent. And -- And let me ask you about your grandchildren. I took all their names down earlier, but rather than go through them one by one, can you tell me, of your grandchildren -- and we can go through them one at a time, but do any of those grandchildren live here in San Antonio or the Bexar County area?

A. The two grandsons do.

Q. Okay. What are their names?

A. Michael James and Eric Lyle.

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Q. And can you tell me are those grandsons both Reynolds, last names?
A. Yes.
Q. Okay. And are those -- Let's start with Michael James Reynolds. Is he married?
A. Yes.
Q. And what is his spouse's name?
A. Stacy.
Q. Did Stacy take his last name?
A. Stacy Reynolds.
Q. And what sort of work does Michael James Reynolds do?
A. Right now he's in between jobs, but he was working for one of those big oil companies --
Q. All right.
A. -- close to the coast.
Q. Thank you, ma'am.
And let's talk about Eric Lyle Reynolds.
A. He's going to Texas A&M.
Q. It's A fine institution of learning.
A. San Antonio A&M.
Q. Oh, at the A&M San Antonio. Excellent.
And how old is -- Let me just ask it this way. He's over 18, I assume?
A. He's what?

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Q. Over 18?
A. Yes.
Q. All right. And is he married?
A. No.
Q. Does he have any children?
A. No.
Q. All right. Are there any other of your grandchildren that live in Bexar County?
A. No.
Q. How about other family members, siblings or --
A. My sister.
Q. -- cousins?
A. My sister lives in Bexar County.
Q. And what is her name?
A. Maxine Pauline Jones. She's the one that has -- had the --
Q. Osteoporosis that we --
A. Yes.
Q. -- talked about earlier. All right.
And is Maxine married?
A. She was. She's a widow.
Q. All right. Other than your sister and the two grandsons that we've talked about here in Bexar County, any other family?

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A. No.
Q. Okay. When -- When you first went under the care of my client, Dr. Rao, did she explain to you what the purpose and treatment goals were that she had for you?
A. I don't recall.
Q. All right. Do you remember any discussions about the -- the desire being controlling the disease, improving quality of life, and prolonging life?
A. No.
Q. And if those conversations happened or discussions took place, you're -- you're just telling me you don't recall it; is that right?
A. Right.
Q. And so -- you told us earlier that your daughter Susan is a good source of information --
A. Yes.
Q. -- about your health care; is that right?
A. Yes.
Q. All right. And you understand that while Dr. Rao was providing you health care, that as that was happening she was creating a record of what was going on; right?
A. What did you say?
Q. And if I've asked you a bad question, please

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do let me know. I meant to say that earlier. If I ask you something that's unclear, I want you to let me know so I can get you a good question.
A. Okay.
Q. But my question is this. You -- You understand that while Dr. Rao was treating you, she was at the same time, each time you would visit her, documenting and making a medical record of those visits; correct?
A. Well, I would hope so.
Q. All right. You don't -- You don't know that to not be true, I supposed --
A. No.
Q. -- is the best answer? All right.
MR. WOOLSEY: Ma'am, that's I think all I have for you at this moment. I'll let your attorney ask you a few more questions if he -- if he has any. And then if I think of any more, I may ask you a couple more. Okay?
THE WITNESS: Okay.
MR. WOOLSEY: Thank you.
MR. POWELL: And I just have a few questions for you, and then we'll -- we'll conclude for the day.
* * * * *

FURTHER EXAMINATION BY MR. POWELL:
Q. Are you -- Do you remember being on a medicine for cancer called Avastin, A-v-a-s-t-i-n, from Dr. Rao?
A. (Witness shakes head side to side.)
Q. Avastin?
A. (Witness shakes head side to side.)
Q. Okay. Do you recall Dr. Rao telling you anything about a risk of bowel perforation from Avastin?
A. (Witness shakes head side to side.)
Q. Nor or -- No?
A. No.
Q. Did you ever have any problem with a bowel perforation that you're aware of?
THE WITNESS: I guess I did, Lyle, huh? No?
MR. REYNOLDS: No. Occasional constipation maybe, but --
MR. POWELL: Okay.
MR. REYNOLDS: -- nothing --
MR. POWELL: Okay.
MR. WOOLSEY: I'll have to object to the sidebar.
MR. POWELL: Yeah. Her husband is

helping her.
MR. WOOLSEY: Something is not right. Let's --
MR. POWELL: Yeah.
MR. WOOLSEY: -- put that in the record.
MR. POWELL: All right. Thank you very much, again, for your testimony today, and we appreciate you working with us on that. I'll pass the witness.
MR. WOOLSEY: Give me just a moment and make sure I'm --
THE WITNESS: It bothered me that I didn't get to see Dr. Rao very much. And I kept asking the people that would come in and ask me questions about how I was feeling or how my health was or this or that, and I'd ask them, "Are you telling Dr. Rao this?"
And they'd always say, "Yes, of course."
And when they wanted to change something, I'd say, "Well, do you ask Dr. Rao?"
So, I understood that they went to Dr. Rao, but it made me -- it didn't make me feel real good not seeing her. I'd see her in the hall. But as far as seeing her and talking with her, the two times were when we first went in, and the second time was when my son -- our son was there and Lyle was there.

We were all there, and she came in and talked with us.
And then at the cl- -- when she let me go, which surprised me. I mean, to let me go and say, "Put her on hospice," to me didn't sound good. Hospice meant death, which I knew, you know, that -- my prognosis or whatever you want to call it. But I believe in a lot of prayer, and I do believe He answers prayer. And that's one reason -- one thing that I couldn't -- I wouldn't give up on.
MR. POWELL: Mrs. Reynolds, I should have asked you if there's anything --
MR. WOOLSEY: Let me object --
MR. POWELL: -- else that you wanted --
MR. WOOLSEY: -- as nonresponsive.
Q. (By Mr. Powell) Yeah. I should have ask you if there's anything else you wanted to say. And you've just I think said it, but were you able to visit with Dr. Rao in person at most of your visits?
MR. WOOLSEY: I'm going to --
A. No.
MR. WOOLSEY: -- object to the form.
Q. (By Mr. Powell) And you weren't happy about the hospice recommendation?
A. No.
MR. WOOLSEY: Objection; leading.

Q. (By Mr. Powell) And why not?
A. Well, it meant death was close.
Q. Right. Okay. I'm going to let him ask --
How many times did you see Dr. Rao personally, do you remember?
A. No, but it wasn't too many times.
Q. And, again, your daughter can tell us about that?
A. Yeah.
Q. Okay. All right.
A. I'd see her in the hall, or I'd hear her in the hall because she's got a sounding voice.
Q. Okay.
A. And I'd see her and hear her in the hall.
MR. POWELL: All right. I'm going to pass and let Mr. Woolsey ask you any final questions.
MR. WOOLSEY: I apologize. I'm just -- Give me one moment. It's a slow-moving train here.
* * * * *
FURTHER EXAMINATION BY MR. WOOLSEY:
Q. Ma'am, I want to ask you whether you've had discussions with any health care providers that were critical of Dr. Rao?
A. No.
Q. You're shaking your head no? Okay.

MR. WOOLSEY: That's all I have.
MR. POWELL: Thank you very much for your time today.
THE WITNESS: Thank you.
THE VIDEOGRAPHER: The deposition --
MR. POWELL: We're done.
THE VIDEOGRAPHER: -- has ended. We're going off the record at 10:39.

(The deposition was concluded at 10:39 a.m.)

*** SIGNATURE WAIVED ***

CAUSE NO. 2018-CI-13942

THELMA LOUISE REYNOLDS, § IN THE DISTRICT COURT
§
Plaintiff, §
§
vs. §
§ BEXAR COUNTY, TEXAS
§
JAYASREE RAO, M.D. and §
ONCOLOGY SAN ANTONIO §
CANCER CENTER NETWORK, §
§
Defendants. § 45TH JUDICIAL DISTRICT

****

REPORTER'S CERTIFICATE

ORAL AND VIDEOTAPED DEPOSITION
OF
THELMA LOUISE REYNOLDS

MARCH 15, 2019

****

I, Deborah A. Koole, Certified Shorthand Reporter in and for the State of Texas, hereby certify to the following:

That the witness, THELMA LOUISE REYNOLDS, was duly sworn and that the transcript of the deposition is a true record of the testimony given by the witness;

That examination and signature of the witness to the deposition transcript was waived by the witness and agreement of the parties at the time of the deposition;

$ _____ is the deposition officer's charges to Plaintiff for preparing the original deposition and any copies of exhibits;

That pursuant to information given to the deposition officer at the time said testimony was taken, the following includes all parties of record and the amount of time used by each party at the time of the deposition:
Jon Powell, Counsel for Plaintiff (0:38)
Brant Mittler, Counsel for Plaintiff (0:00)
William C. Woolsey, Counsel for Defendants (0:09)

I further certify that I am neither counsel for, related to, nor employed by any of the parties in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of this action.

The deposition was delivered in accordance with Rule 203.3, and a copy of this certificate, served on all parties shown herein, was filed with the Clerk.

Certified to by me on this 18th day of March, 2019.

Deborah A. Koole, CSR
Texas CSR #6699
Expiration: 1/31/2021

Koole Court Reporters of Texas
Firm Registration No. 413
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Exhibit C.

Lyle Reynold's deposition transcript dated August 19, 2019.

CAUSE NO. 2018-CI-13942

THELMA LOUISE REYNOLDS,	§	IN THE DISTRICT COURT
	§	
Plaintiff,	§	
	§	
vs.	§	
	§	BEXAR COUNTY, TEXAS
	§	
JAYASREE RAO, M.D. and	§	
ONCOLOGY SAN ANTONIO	§	
CANCER CENTER NETWORK,	§	
	§	
Defendants.	§	45TH JUDICIAL DISTRICT

****

ORAL AND VIDEOTAPED DEPOSITION
OF
LYLE REYNOLDS

AUGUST 19, 2019

****

ORAL and VIDEOTAPED DEPOSITION OF LYLE REYNOLDS, produced as a witness at the instance of Plaintiff's counsel, and duly sworn, was taken in the above-styled and numbered cause on August 19, 2019, from 10:02 a.m. to 10:25 a.m., before Deborah A. Koole certified Shorthand Reporter in and for the State of Texas, reported by computerized stenotype machine at Heritage Creek Assisted Living, 6538 Eckhert Road, San Antonio, Bexar County, Texas, pursuant to the Texas Rules of Civil Procedure and the provisions stated on the record or attached hereto.

APPEARANCES

FOR THE PLAINTIFF:

Mr. John "Mickey" Johnson
THE POWELL LAW FIRM
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San Antonio, TX 78205
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FOR THE DEFENDANTS:
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ALSO PRESENT:

Ms. Deborah A. Koole, CSR

Mr. Pete Resendez, Videographer

INDEX

* * * * *

NO EXHIBITS MARKED.

THE VIDEOGRAPHER: This marks the start of the Lyle Reynolds deposition. Today is Monday, August 19, 2019. The time on record is 10:02.

LYLE REYNOLDS,
having been first duly sworn through the interpreter, testified as follows:

* * * * *

EXAMINATION

BY MR. JOHNSON:

Q. Mr. Reynolds, you and I have talked a little bit before, but I'm --

A. Yes.

Q. -- Mickey Johnson, and I'm representing your wife in this case. You do understand that we are here in a deposition related to a case, a medical malpractice case? Do you understand that?

A. Yes.

Q. Okay. And could you state your full name for the record.

A. Garland Lyle Reynolds.

Q. Okay, thank you. And what is your date of birth, sir?

A. 5 October 1928.

Q. So, you are 90 years old today as you a sit there?

A. Yes.

Q. Okay, very good. And you were married to Thelma Louise Reynolds; is that correct?

A. Yes.

Q. And how long were y'all married for?

A. 64 years plus.

Q. 64-plus years?

A. Yes.

Q. Wow, that's very impressive.

MR. WOOLSEY: Object to form.

Q. (By Mr. Johnson) I wanted to talk to you today a little bit about how she was affected by the chemotherapy treatment that she got --

A. Yes.

Q. -- from Dr. Rao. You do understand that your wife did get diagnosed with cancer, correct?

A. Yes.

Q. And she also was diagnosed with peripheral neuropathy, correct?

A. Yes.

Q. Okay. Can you explain to the jury how your wife was affected by the neuropathy. What did it do to her hands?

MR. WOOLSEY: Objection; form.

THE WITNESS: Pardon me?

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MR. JOHNSON: Go ahead.
MR. WOOLSEY: I'm making objections to his questions.
THE WITNESS: Oh.
MR. WOOLSEY: Unless he tells you not to answer for some reason -- I'm just objecting for -- for a time down the road.
THE WITNESS: Oh, okay.
MR. WOOLSEY: I'm just complaining about the type of his questions.
THE WITNESS: Okay.

A. She was outwardly -- Her feet were affected in that they bent one way and couldn't be relied on to be walked on, at all. They stayed that one way. She had a pair of shoes made, and they were taken at Warm Springs and not returned. So, that was the way she was. She couldn't walk.

Her hands were affected from the first joint of each finger down to the end of each finger, to where there was no feeling. And she couldn't control that, at all. So, that restricted her use of her hands completely to where she couldn't sew, she couldn't eat except if she grabbed it like a caveman would (motioning). She just couldn't do anything with her hands.

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Q. (By Mr. Johnson) Was she able to hold a fork and feed herself?

A. No.

Q. Was she able to hold a cup without spilling water or --

A. No.

Q. -- juice? No, okay.

MR. WOOLSEY: Form.

Q. (By Mr. Johnson) Now, how -- How did this make her feel, that she was unable to use her hands?

A. When she --

MR. WOOLSEY: Objection; form.

A. -- recovered with -- not recovered. When she realized that she could not control her fingers -- particularly because she had decided that in here, the one thing she could do is sew, so she had her machine in here and was sewing. When this happened, she realized finally that she would never again be able to do that, and she became very depressed. And I think subsequently that's probably what killed her.

Q. Now --

MR. WOOLSEY: Objection; nonresponsive.

Q. (By Mr. Johnson) Before your wife passed away, was she helpful or did she help you with taking care of yourself, as well?

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A. She couldn't, no.

Q. She couldn't?

A. No. I went to -- I went to her room down the hallway every day, eight or ten times, talking with her, checking with her, just being with her, but it affected -- affected her. I'm sorry.

Q. That's okay.

A. But it was hard to see. And then -- She could talk, and we did talk. But she had always had the hope, up until the last, maybe the last few weeks --

Q. Uh-huh.

A. -- that she could -- would be able to do stuff. She couldn't write. She couldn't -- She could talk, and that was about it. She was -- had trouble hearing, but that was probably unre- -- unrelated to this. But she couldn't do anything but lay there and couldn't move. She couldn't take care of herself in any way.

She could press the button, the call button, by grasping it and pushing it with her hand. That was the extent of her use for her hands. It was very hard to see. And she had been so active. I'm sorry.

Q. You're fine. So, I wanted to ask you --

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MR. WOOLSEY: Objection; nonresponsive.

Q. (By Mr. Johnson) Before she was diagnosed with the cancer and neuropathy, it sounds like you indicated that she was living an active lifestyle.

A. She was.

Q. What types of things was she doing before she had neuropathy, or would y'all do things together?

A. Yes.

Q. What sorts of things would y'all do?

A. Well, we would go out to eat once in a while. She worked around the house and kept the house clean, did the cleaning and so on and so forth, everything associated with the housework. She worked outside quite a bit, as much as she could. She liked plants, so she was working somewhat with them. She did a lot of sewing. She had sewed from the beginning of our marriage practically --

Q. Yeah.

A. -- until -- up until this time.

Q. Uh-huh.

A. And she spent hours in there making quilts primarily, or lap covers, for elderly people. Then she would give them to somebody who would distribute them around to nursing homes or wherever they could be used for babies. I mean this was what she wanted --

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Q. Right.
A. -- to do, and that's what she settled to do. She was also active in the church. And she wrote notes concerning her childhood up to her parents' deaths, concerning their raising and stories they would tell her. And she loved reading them over and making sure that they were right.
And she did have beautiful handwriting which deteriorated, of course, to where you couldn't hardly decipher it even because there was no holding of a pencil except if you held it like that (motioning) or tried to write something that way.
Q. Uh-huh.
A. So, she didn't -- We went to church nearly every Sunday, and she tried leading a women's group there, she tried teaching children there, and she tried being an educational director. And one of her -- She was an elder in our church for quite a long time. But when we changed churches -- this was in 2010 -- then she became active in this new church. So, that's where what she did I'm talking about now rather than the 40 years before that.
Q. Okay.
A. So --
Q. And do -- You and Thelma, y'all had children;

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is that right?
A. We had two children, David Lyle Reynolds and Thelma -- Susan Reynolds.
Q. And did you have any grandchildren?
A. Seven grandchildren.
Q. And did Thelma spend a lot of time with her children and your grandchildren?
A. She spent all the time that she could. The daughter was in the military with her husband and then, of course, went overseas. And we went over to -- She went over to England twice, to Italy once, with the children. I was working for the government, so I went with her when I could. And I also went -- was gone TDY a number of times, east and west --
Q. Right.
A. -- and around the country, too. So, she kept up and managed the household and took care of the kids as much as was required and more.
Q. And once she was diagnosed with cancer and neuropathy, she was no longer able to do that; is that true?
MR. WOOLSEY: Form, leading.
A. She couldn't. There was no way she could walk. She couldn't even properly manipulate a wheelchair. She could sit in a wheelchair if her feet

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were -- were moved so they rested on the footrests from the wheelchair, but that was the only way she could get around. And, of course, not being able to use her hands properly, she couldn't do much with the wheelchair --
Q. (By Mr. Johnson) Yeah.
A. -- besides have somebody move her.
Q. Right.
A. And that just defeated her over time because she constantly was looking for ways to try to do something mainly for others.
Q. Right.
A. She thought of -- She loved children. She tried to think of ways she could help them and people in general. And when she finally realized that she wouldn't be able to ever again do what she wanted to, she started going downhill --
Q. Uh-huh.
A. -- and never recovered.
Q. Okay.
MR. WOOLSEY: Objection; nonresponsive.
MR. JOHNSON: I may ask you one or two more questions, but I'm going to hand it over to opposing counsel if he has any questions for you.
* * * * *

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EXAMINATION BY MR. WOOLSEY:
Q. Mr. Reynolds, I'm sorry we have to meet under these circumstances, and I'm very sorry for the loss of your wife. Do you accept my --
A. Okay.
Q. -- condolences to you, sir?
A. What?
Q. Do you accept my condolences to you, sir? I'm very sorry --
A. Oh, yes.
Q. -- that we're --
A. Oh, yes.
Q. -- here under these circumstances.
A. Oh, yes. You didn't cause it.
Q. Let me -- Let me ask you, sir, just a couple of quick questions. All right?
What -- What's the name of the church that y'all were attending most recently?
A. Most recently was South Memorial Christian Church. That was the last since 2010.
Q. What was the name of the church that y'all attended prior to that?
A. Marbach Christian Church.
Q. You said Marbach Christian Church?
A. Yes.

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Q. How long were y'all members there? I assume you were members at Marbach Christian Church.
A. Yes.
Q. How long were y'all members there?
A. We went there in 19- -- I'm backing it up. '55, '56, '57 -- 1963 I think, two or three.
Q. You can get close -- Close enough. 1962 or three?
A. Whenever the church founded. Yeah, we were founding members at that time.
Q. And you stayed there until 2010?
A. Yes.
Q. All right, sir. What type of work did you do before retiring?
A. I was an air intelligence analyst at Security Service.
Q. Did you say air intelligence --
A. -- analyst.
Q. Air intelligence analyst.
And you said that was with the government?
A. The Air Force, yes.
Q. Thank you for your service.
A. Okay.
Q. And --

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A. Well, that was civilian primarily.
Q. Okay.
A. Four years of civilian and -- I mean four years military and the rest civilian.
Q. All right. So, four years active in the Air Force and then as a civilian?
A. Yes.
Q. All right, sir. And you mentioned your -- your children. Neither of them live here in San Antonio or Bexar County; is that right?
A. At that time, no. Susan does now.
Q. She now lives in San Antonio?
A. Yes.
Q. When did Susan -- and her -- Is her last name Reynolds?
A. She goes by Reynolds right now, yes.
Q. All right. When did Susan move back in to San Antonio?
A. Permanently, when she was divorced. I'm trying to remember, 19 -- 20 -- I'm sorry. Four or five years ago.
Q. Sometime 2012, '13?
A. Somewhere in there, yes.
Q. Okay. And are any of your grandchildren over the age of 18, sir?

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A. They all are.
Q. All of your grandchildren are?
A. Yes.
Q. Do -- Does Susan have children that live here in San Antonio?
A. She has one in San Antonio.
Q. What's that -- What's that kid's name?
A. Chase Hunter Downey.
Q. Chase Hunter --
A. -- Downey.
Q. -- Downey?
How old, if you know, is Chase?
A. Oh, boy. 19- -- she was born in -- She was married in 1986. Bobby was born in 1988. Chase was born in 1989, I think.
Q. Making him 29 or 30 years old?
A. Yes.
Q. All right. Do you know what kind of work Chase -- Does Chase have a job here in town?
A. Yes.
Q. Do you know what he does?
A. I'm trying to remember because he's had so many jobs.
Q. It's common.
A. I think he's working in a -- Oh, man. I

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should know this, and I just -- It escapes me at the moment.
Q. That's all right. Do you -- Do you know what kind of industry it is? Is he in the construction industry, oil and gas? Does he sell widgets?
A. He was in construction, working with masonry.
Q. Okay.
A. But I think he changed jobs.
Q. Okay.
A. And what he's doing right now I can't remember. My memory is shot.
Q. Fair -- Fair enough. More interesting things to talk about than his job, I imagine.
Any other grandchildren that live here in San Antonio other than Chase?
A. Eric is -- he has two boys of David's. Michael is working with the oil industry in some capacity.
Q. And is Michael's last --
A. And --
Q. -- name Reynolds?
A. What?
Q. Michael Reynolds?
A. Yes.
And Eric Reynolds is working as going to

college at Texas A&M San Antonio.

Q. Very well. And does David, your son, does he live -- he doesn't live here in town, does he?

A. No, not yet. He's moving here and having a house built. Retires up there next month in Bedford and having a house built here, which he plans to move into late in the year. He's hoping to I should say.

Q. Mr. Reynolds, did you go with -- with your wife to any of the doctor's visits to Dr. Rao's office when she was under her care?

A. Yes.

Q. Do you recall any specific conversations with Dr. Rao from that time frame?

A. I remember the last one.

Q. Can you tell me what --

A. -- specifically.

Q. -- what you recall about that last conversation.

A. Dr. Rao came -- called us all in -- my wife, myself, my son David, and Susan, and said, in essence, that she had treated Louise all that she could and she couldn't treat her anymore. This was after 18 months of treatment with chemo. And she left the room. That was it. She just left us all crying and wondering what happened because it was so unexpected.

And it just -- We had nowhere to go, so we started looking for another cancer doctor, which -- Louise and my son. My daughter subsequently found, but that's another story.

Dr. Rao, that was essentially what the last meeting we had with her in so many words. She just cut us off completely. I had my doubts about her, but that's a personal opinion from the time it started and particularly the last six months because I had heard about Opdivo on TV.

And their claim of extending your life was theoretically correct, but their -- their advertisement said we can extend your life. Well, they subsequently found out that it was six weeks, the extension, which was to me nothing. But it took her six months of treatment with that before she called halt to the whole thing of 18 months.

I went with my wife to weekly appointments a number of times, not always. Somebody accompanied her always and was with her. My daughter, my son, or -- I think that was them or me. I don't believe anybody else accompanied her there.

She saw Dr. Rao once in a while, but mainly Dr. Rao communicated by telephone with the aide who talked with Louise and treated her. So, that's

really all I know. She was hooked up every week for an hour, two hours, or three hours, to my knowledge, for whatever was in the bag. I don't know what.

Q. You're -- You're not a physician, right?

A. That's right.

Q. Okay. I'm not going to quiz you on the medication.

A. Please don't.

Q. How's that?

A. Please don't. My daughter could rattle them off to you, but I can't.

MR. WOOLSEY: Fair enough. Mr. Reynolds, I think that's all I have to ask you at this time. And so, I appreciate you answering my questions.

THE WITNESS: Okay, thank you.

* * * * *

FURTHER EXAMINATION BY MR. JOHNSON:

Q. Mr. Reynolds, you said that the last meeting that you had with Dr. Rao, she left the room and the family was crying; is that correct?

A. We all were.

Q. And --

A. She just walked out. You know? She told us she couldn't do any more and walked out.

Q. Do you think she could have handled that last meeting better?

A. In so --

MR. WOOLSEY: Objection; form.

A. -- many words, I mean that was it. So, I felt -- we all felt like we were abandoned at that child -- at that time, like a child that just had been left standing in the middle of the street. But it was a shock.

MR. JOHNSON: Okay. Well, I don't have any more questions for you. I appreciate your time, and I think that's the end of the deposition.

MR. WOOLSEY: Yeah, that's it. I don't have anything else for you, sir.

THE WITNESS: Okay.

THE VIDEOGRAPHER: This concludes the deposition.

THE WITNESS: Thank you.

THE VIDEOGRAPHER: Going off record at 10:25.

(The deposition was concluded at 10:25 a.m.)

*** SIGNATURE WAIVED ***

CAUSE NO. 2018-CI-13942

THELMA LOUISE REYNOLDS, § IN THE DISTRICT COURT
§
Plaintiff, §
§
vs. §
§ BEXAR COUNTY, TEXAS
§
JAYASREE RAO, M.D. and §
ONCOLOGY SAN ANTONIO §
CANCER CENTER NETWORK, §
§
Defendants. § 45TH JUDICIAL DISTRICT

****

REPORTER'S CERTIFICATE

ORAL AND VIDEOTAPED DEPOSITION
OF
LYLE REYNOLDS

AUGUST 19, 2019

****

I, Deborah A. Koole, Certified Shorthand Reporter in and for the State of Texas, hereby certify to the following:

That the witness, LYLE REYNOLDS, was duly sworn and that the transcript of the deposition is a true record of the testimony given by the witness;

That examination and signature of the witness to the deposition transcript was waived by the witness and agreement of the parties at the time of the deposition;

$ _____ is the deposition officer's charges to Plaintiff for preparing the original deposition and any copies of exhibits;

That pursuant to information given to the deposition officer at the time said testimony was taken, the following includes all parties of record and the amount of time used by each party at the time of the deposition:
Mickey Johnson, Counsel for Plaintiff (0:13)
William C. Woolsey, Counsel for Defendants (0:10)

I further certify that I am neither counsel for, related to, nor employed by any of the parties in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of this action.

The deposition was delivered in accordance with Rule 203.3, and a copy of this certificate, served on all parties shown herein, was filed with the Clerk.

Certified to by me on this 26th day of August, 2019.

Deborah A. Koole, CSR
Texas CSR #6699
Expiration: 1/31/2021

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Exhibit D.

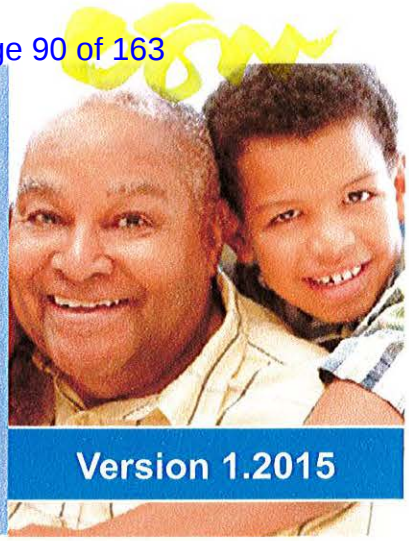
National Comprehensive Cancer Network Quick Guide article titled "Non-Small Cell Lung Cancer."

National Comprehensive Cancer Network®

NCCN QUICK GUIDE™

Non-Small Cell Lung Cancer

Treatment Options



Version 1.2015

This NCCN QUICK GUIDE™ sheet summarizes key points from the complete *NCCN Guidelines for Patients®: Non-Small Cell Lung Cancer.* These guidelines explain which tests and treatments are recommended by experts in cancer. To view and download the guidelines, visit NCCN.org/patients or, to order printed copies, visit Amazon.com.

	NCCN Guidelines for Patients® Page Number
How do doctors choose treatment options?	
Treatment options for lung cancer greatly depend on the cancer stage. Options for one or more related tumors are listed next. Besides treatment, ask for supportive care. You can get help for symptoms, managing your care, deciding your treatment, and more.	57
What are the options for stage I?	
▪ Surgery to remove the cancer and lymph nodes. Then, more surgery or radiation therapy if it's likely that not all the cancer was removed. If stage IB, chemotherapy may be added to either option. ▪ Radiation therapy, and if stage IB, maybe chemotherapy, too.	58
What are the options for stage II?	
No growth of tumor into other tissues (No invasion)	▪ Surgery to remove the cancer and lymph nodes. Then, chemotherapy if chances are low that cancer remains. If high, surgery with or without chemotherapy or chemoradiation alone. ▪ Radiation therapy and maybe chemotherapy, too. ▪ Chemoradiation alone — 62
Superior sulcus tumor	▪ Chemoradiation then surgery then chemotherapy. ▪ Chemoradiation alone — 64
Growth of tumor into other tissues (Invasion)	▪ Surgery to remove the cancer and lymph nodes. Then, chemotherapy if chances are low that cancer remains. If high, surgery with chemotherapy or chemoradiation alone. ▪ Chemoradiation or chemotherapy followed by surgery. You may have a second surgery if not all of the cancer was removed. ▪ Chemoradiation alone — 64

EXHIBIT Rao - 5 12-18-19 DK

PENGAD 800-631-6989

What are the options for Stage III?

No growth of tumor into other tissues (No invasion)	▪ Surgery to remove the cancer and lymph nodes. Then, chemotherapy if chances are low that cancer remains. If high, you may have chemoradiation. ▪ Chemotherapy then surgery. Radiation therapy may be received before or after surgery. More chemotherapy may follow surgery. ▪ Chemoradiation alone	68
Superior sulcus tumor	▪ Chemoradiation then surgery then chemotherapy. ▪ Chemoradiation then more chemotherapy. ▪ Chemoradiation alone	72
Growth of tumor into other tissues (Invasion)	▪ Surgery to remove the cancer and lymph nodes. Then, chemotherapy if chances are low that cancer remains. If high, surgery with chemotherapy or chemoradiation alone. ▪ Chemoradiation or chemotherapy then surgery. You may have a second surgery if not all of the cancer was removed. ▪ Chemoradiation alone	74

What are the options for widespread Stage IV?

Abnormal EGFR	▪ Erlotinib or afatinib.	78
Abnormal ALK	▪ First, crizotinib and if it fails, then ceritinib.	80
Normal or unknown EGFR or ALK status	▪ Chemotherapy and if the cancer grows, try another chemotherapy. Drugs that stop cancer from getting food may be added. An immune-boosting drug is sometimes an option. ▪ Supportive care if chemotherapy will be harmful.	82

Are multiple unrelated tumors treated the same?

Surgery is preferred to try to cure. Otherwise, treatment is the same as for stage IV.	90

How do I decide between options?

Ask your doctors many questions. Also, you could get a second opinion, attend support groups, and compare pros and cons.	97

Exhibit E.

Jayasree Rao, M.D.'s deposition transcript dated December 18, 2019.

CAUSE NO. 2018-CI-13942

THELMA LOUISE REYNOLDS,	§	IN THE DISTRICT COURT
	§	
Plaintiff,	§	
	§	
vs.	§	
	§	BEXAR COUNTY, TEXAS
	§	
JAYASREE RAO, M.D. and	§	
ONCOLOGY SAN ANTONIO	§	
CANCER CENTER NETWORK,	§	
	§	
Defendants.	§	45TH JUDICIAL DISTRICT

****

ORAL AND VIDEOTAPED DEPOSITION
OF
JAYASREE RAO, M.D.

DECEMBER 18, 2019

****

ORAL and VIDEOTAPED DEPOSITION OF JAYASREE RAO, M.D., produced as a witness at the instance of Plaintiff's counsel, and duly sworn, was taken in the above-styled and numbered cause on December 18, 2019, from 9:59 a.m. to 3:46 p.m., before Deborah A. Koole certified Shorthand Reporter in and for the State of Texas, reported by computerized stenotype machine at the offices of Woolsey & Woolsey, 310 South St. Mary's Street, Suite 1030, San Antonio, Bexar County, Texas, pursuant to the Texas Rules of Civil Procedure and the provisions stated on the record or attached hereto.

APPEARANCES

FOR THE PLAINTIFF:
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FOR THE DEFENDANTS:

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ALSO PRESENT:

Ms. Deborah A. Koole, Certified Shorthand Reporter
Mr. Gary Gutierrez, Videographer

INDEX

* * * * *

EXHIBITS

EXHIBITS CONTINUED

EXHIBITS CONTINUED

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(Exhibit 1 was marked.)
* * * * *
THE VIDEOGRAPHER: This marks the start of Jayasree Rao, M.D. deposition. Today is Wednesday, December 18, 2019. We're going on the record at 9:59.
JAYASREE RAO, M.D.,
having been first duly sworn, testified as follows:
EXAMINATION BY
BY DR. MITTLER:
Q. Could you please state your full name.
A. My first name is Jayasree. Last name is Rao, R-a-o.
Q. Okay. Do you have any middle name?
A. It's "N" as in Nancy, Nagaraja.
Q. How do you spell that?
A. N-a-g-a-r-a-j-a.
Q. And, Dr. Rao, my name is Brant Mittler. And you understand that I represent the Plaintiff in this lawsuit against you? Do you understand that?
A. Yes.
Q. Okay. Could you please state your business address.
A. I have two offices. One of them is at Stone Oak, and the other downtown.
Q. And in pur- -- For the purposes of contacting

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you at a business address, which address should be used?
A. I --
MR. WOOLSEY: You can contact her through me.
MR. POWELL: Well, I'd like to know what her business address is.
MR. WOOLSEY: You can have her business address. I just want to make sure you contact her through me.
DR. MITTLER: Well, I understand that. Okay?
MR. WOOLSEY: Okay. I just --
DR. MITTLER: I think it's a standard part of depositions --
MR. WOOLSEY: I've had --
DR. MITTLER: -- to ask the doctor's business address. And when she has -- I'm going to ask her for all of her business addresses.
MR. WOOLSEY: I agree --
DR. MITTLER: Okay?
MR. WOOLSEY: -- you're entitled to it. I've had in the last -- in the last week three plaintiffs lawyers contact my clients direct. And so, it's --

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DR. MITTLER: Well, I've never done that, and please don't accuse -- please don't imply that I would do it.
MR. WOOLSEY: I'm --
DR. MITTLER: Okay?
MR. WOOLSEY: -- just being belts and suspenders, Brant.
DR. MITTLER: All right.
Q. (By Dr. Mittler) Could you please tell us -- Do you have a principal business address?
A. 202 Baltimore Avenue.
Q. In San --
A. 78215.
Q. Is that in San Antonio, Texas?
A. Uh-huh.
Q. And is that where you have your pri- -- your main office, where you, say, do your work every day, in your capacity that we'll discuss, with your oncology practice?
A. Yes.
Q. And are the other offices -- Are the other office or offices satellite offices?
A. Yes.
Q. How many total offices do you have in your practice where you practice oncology?

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A. Only two.
Q. Only two, okay. And have you been in a deposition before?
A. I don't think so.
Q. You've never been deposed under oath in a deposition?
A. (Witness shakes head side to side.)
Q. Do you understand that you're under oath today?
A. (Witness nods head up and down.)
Q. And that you -- Do you understand that the laws of perjury apply to your testimony today?
A. Yes.
Q. Okay. You understand that you're being videotaped; correct?
A. Yes.
Q. And do you understand that the videotape and your deposition testimony can be played to a jury just like you were live in a courtroom?
A. If you say so.
Q. Well, do you understand that?
A. Okay.
Q. And do you -- Could we have some agreements? Do you agree that if you do not understand my question that you'll ask me to repeat it or clarify my question?

A. Yes.
Q. And do we have an agreement that if an answer calls for a "yes" or a "no," that you will answer as "yes" or "no" as opposed to "uh-huh" or "uh-uh"?
A. Okay.
Q. Do you understand that?
A. Yes.
Q. And rea- -- And you understand the reason is that we have a court reporter taking down your response and we want the court reporter to be able to understand your response? Do you understand that?
A. Yes.
Q. Are you -- Do you have any medical conditions today or any reason that you can't give your best testimony today?
A. No.
Q. Is -- Now, how long have you been licensed to practice in the state of Texas?
A. Seventeen years.
Q. And what is your -- Do you have a medical specialty?
A. I'm a hematologist/oncologist.
Q. And is your basic training in internal medicine?
A. And geriatrics.

Q. And geria- -- And where did you do your internal medicine training?
A. In Easton Hospital. Easton, Pennsylvania.
Q. And where did you do your hematology training?
A. Hematology/oncology, I did it here at UT San Antonio.
Q. And so, it was at the university medical center in San Antonio?
A. Yes.
Q. And what years were you in training for hematology/oncology?
A. It was 2002 to 2005.
Q. So, it was a three-year fellowship?
A. Yes.
Q. And did you graduate from that fellowship in good standing?
A. Yes.
Q. Did you -- have you ever taken boards that --
A. Yes.
Q. Okay. Let's have another agreement. Can you agree that you'll let me finish my question before you attempt to answer?
A. Yes.
Q. Okay. Because sometimes my -- I'm a little

bit slow in asking the question, and you're -- you know the answer and you'll anticipate it. But, again, for purposes of the court reporter, we have to have a question completed and then you're allowed to answer. Do you understand that?
A. Yes.
Q. Okay. So, did you ever take the boards in internal medicine?
A. Yes.
Q. And when was that?
A. It was 2002.
Q. And did you pass the boards?
A. Yes.
Q. Okay. Did you have to take boards in hematology/oncology?
A. Yes.
Q. And when did you take those?
A. 2005.
Q. And did you pass those?
A. Yes.
Q. Was it necessary to be recertified in those boards?
A. I'm not sure if it's necessary.
Q. Were you ever recertified?
A. No.

Q. Has there -- Has there ever been an issue at the Texas Medical Board about your board certification?
A. No.
Q. Let me hand you what's been marked as Exhibit --
DR. MITTLER: Did we mark that as an exhibit yet?
MR. WOOLSEY: Yes.
DR. MITTLER: Did we mark it already as 1?
MR. WOOLSEY: Yes.
DR. MITTLER: Okay.
Q. (By Dr. Mittler) Let me just do a little bookkeeping here. We have marked as Exhibit 1 the -- a set of medical records on paper from your office, regarding the Plaintiff in this case, Thelma Louise Reynolds; is that correct, Dr. Rao?
A. These are her records, yes.
Q. And these are all the records in your possession, at your office, regarding Thelma Reynolds; is that correct?
A. To the best of my knowledge, yes.
Q. Does this also include billing records?
A. Yes.
(Exhibit 2 was marked.)

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Q. (By Dr. Mittler) Let's -- I'm going to hand you what's been marked Exhibit 2.
A. Okay.
Q. Exhibit --
DR. MITTLER: I'm sorry.
MR. WOOLSEY: Thank you.
Q. (By Dr. Mittler) Exhibit 2 is a copy of a -- of a printout from the Texas Medical Board website, regarding you, that I believe was printed out yesterday. Can you take a look at that. Does that -- First of all, does that pertain to you?
A. Yes.
Q. Is that you?
A. Yes.
Q. Do you see that there is some information there about a -- I guess a matter that came before the board regarding your advertising that you were board certified?
A. Yes.
Q. And they're having you agree to an agreement that you not advertise anymore that you were board certified; is that accurate?
A. Yes.
Q. And you signed that agreement in October of 2016; is that correct?

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A. What agreement, sir? That I will not advertise?
Q. A remedial plan, yes.
A. Oh, yes.
Q. Is that -- Is that correct?
A. Uh-huh.
Q. All right. And so, how did that come about if you were board certified?
A. So, we previously had our business office in Floyd Curl Drive. So, apparently, they were sending communications to that address for two years, and it kept going back to them.
At that time that they said, you know, when it was first started, I was well within board certification. And so, they were looking at cached filings on -- so, by the time I -- it came to me, finally, it was two and a half years later.
And I did have somebody represent me, and they said it was easier to do this than to go to Austin to fight it.
Q. Were you a -- Was there a period of time when you were not board certified?
A. My board certification lapsed after ten years.
Q. Okay. So, that would have been in when?

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A. 2015.
Q. It lapsed, all right.
And then -- So, there was a period of time that you were advertising you were board certified when you were not board certified; is that correct?
A. I was not advertising anything, sir. It was in our previous in whatever they were looking at, at some website.
Q. Well, you were -- you were -- you said you were -- Were you board certified initially in 2005?
A. Yes.
Q. And that board certification was good for ten years; correct?
A. Yes.
Q. All right. And so, when the board certification lapsed in 2015, when were you recertified?
A. I did not recertify.
Q. So, are you board certified now?
A. I am not board certified now.
Q. And just -- let's just -- because the remedial plan you signed, the findings were that you improperly advertised that you were board certified on your website and your Texas Medical Board profile when she is not board certified; is that correct?

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A. That was this issue about, yes.
Q. Is that correct?
A. What is correct, sir?
Q. That --
A. I don't understand your question.
Q. That those were the findings of the Texas Medical Board, that you had advertised you were board certified on your -- on your website and your Texas Medical Board profile, when you were not board certified.
A. So, we had a different company with a different address, and the Texas Medical Board was communicating with an address that was no longer, you know, available, so they kept -- they kept returning it. And they were looking at cached files.
So, in the, you know, whatever I was practicing, all the information was updated. And I wanted to go to Austin to fight it, and my attorney said it was easier to just go through this.
Q. All right. Were you board certified in 2016?
A. Till December 2015 I was.
Q. You were board certified?
A. Yes.
Q. In 2016, were you board certified?
A. No.

Q. In 2017, were you board certified?
A. No.
Q. In 2018, were you board certified?
A. No.
Q. In 2019, are you board certified?
A. No.
Q. Your Texas Medical Board profile -- could I see, I'm sorry, Exhibit 1 [sic]. The -- if you turn over to the -- If you turn to the page that has specialty certifications up at the top, do you see that up at the top about specialty certifications?
A. Uh-huh.
Q. And you see this is your current Texas Medical Board profile? Do you see that? You can look on the first page and see when it was printed out.
A. Okay.
Q. All right. Now, that -- That indicates that you're board certified; is that correct?
A. It says it was board certified at that date, at that year.
Q. Well, aren't you representing to the public right now that you are board certified?
A. No, sir.
Q. Well, it says board certification 2015.
A. This is the first time I'm looking at it.

I'll have to talk to my people who keep up with all the -- the credentialing people.
Q. So, would you agree that that is inaccurate?
A. I don't understand what this whole thing looks like. I will definitely talk to my credentialing people.
Q. Well, do you have someone else send in your --
A. Yes.
Q. -- information on re-credentialing to the Texas Medical Board?
A. Yes, sir.
Q. Do you check it before you send it in?
A. No, sir.
Q. Do you -- Don't you think it would be wise to check what you send in to the Texas Medical Board regarding your board certification?
THE WITNESS: Mr. Woolsey, does this look like -- I don't understand this.
A. I would like to think that it expired in 2015.
DR. MITTLER: I'm going to object as nonresponsive.
Q. (By Dr. Mittler) So, my question is, don't you think it's a good idea to check the information

being sent in to the Texas Medical Board about the status of your board certification?
A. Yes, sir.
Q. Does the word "expired" appear anywhere on that Texas Medical Board website, pertaining to your board certification?
A. I don't see that.
Q. So, the answer is no; correct?
A. I'll definitely talk to my credentialing people about it.
Q. So, the answer is no, the word "expired" does not appear anywhere relating to your board certification; correct?
A. Yes.
Q. Is there any -- You've had a chance now to review that printout from the Texas Medical Board on their website, pertaining to you. Have you found anything else that's incorrect on that printout?
A. I have two other nurse practitioners, and their names are not in here.
Q. And who are they?
A. There's a lady called Shaneeka Hamlett, H-a-m-l-e-t [sic]. They were just recruited recently.
Q. Shaneeka?
A. Yeah.

Q. And who else?
A. Selina, S-e-l-i-n-a. Her last name is K-a-d-i-w-a-l.
Q. And these are nurse practitioners who you supervise?
A. Yes, sir.
Q. And you have a legal duty to report the nurse practitioners you supervise to the Texas Medical Board; correct?
A. I think so.
Q. And who -- Who reports that for you?
A. My credentialing people.
Q. Okay. Do you know how long you have to report that to the Texas Medical Board after they're hired?
A. I don't know, sir.
Q. Can you tell the jury why you didn't seek board recertification in 2015?
A. Because I was not well.
Q. So, it was because of illness?
A. (Witness nods head up and down.)
Q. And is that the reason that you haven't sought board certification since December of 2015?
A. Yes.
Q. But you're -- you're not -- because of

illness you can't recertify; is that correct?
A. I haven't had the time to do it.
Q. Are you practicing full-time?
A. Yes.
Q. How many hours a week do you practice?
A. 60 to 65 hours.
Q. So, whatever illness you have is not preventing you from practicing over 60 hours a week; is that correct?
A. Yes.
Q. And the illness you have is not -- again, not preventing you from giving your best testimony today; is that correct?
A. Yes.
Q. And you're not on any medications today that would prevent you from giving your best testimony?
A. No.
Q. Now, we talked about your -- your office record, Exhibit 1. Did you go over this record in detail prior to today's deposition?
A. Not all of it.
Q. Do you have a specific recall of Mrs. Reynolds?
A. About anything in specific?
Q. Well, do you have a specific recall of what

Mrs. Reynolds looked like --
A. Yes.
Q. -- when you saw her?
A. Yes.
Q. And what did she look like?
A. She was very pleasant and anxious.
Q. And do you remember how tall she was or how much she weighed?
A. I don't remember that now.
Q. Do you remember talking to any family members who were with her?
A. Yes. I've met her husband and her son and daughter.
Q. And do you -- What recall do you have about her son and daughter?
A. Her son came maybe three times during the time I took care of her. Her daughter most every time she brought her. Mrs. Reynolds was very appreciative, always complimentary, sweet. And they, the daughter and Mrs. Reynolds, seemed to have conflict. And so, the daughter felt like she -- Mrs. Reynolds wasn't, like, forthcoming with some information. So, they were frequently having discord, the daughter and Mrs. Reynolds.
Q. What was her daughter's name?

A. I don't remember.
Q. And what was the discord that Mrs. Reynolds and her daughter had that you saw? What was it about?
A. There wasn't just one time. You know, there were many times.
Q. Well, what -- What did the daughter want that Mrs. Reynolds didn't want let's say?
A. Maybe that the daughter felt Mrs. Reynolds wasn't completely telling all her, you know, symptoms.
Q. Did the daughter think that Mrs. Reynolds was having -- was sicker than she was letting you and your office staff know about?
A. I think that's what she was trying to convey.
Q. Did the daughter want Mrs. Reynolds to have different treatments than what you were prescribing?
A. Her daughter from the beginning always seemed to think Mrs. Reynolds should think about, you know, not getting treated.
Q. So, is it your testimony that Mrs. Reynolds' daughter did not want Mrs. Reynolds treated?
A. She, I think, felt that Mrs. Reynolds wasn't forthcoming with all her symptoms and she wasn't -- you know, when we asked "How are you doing?" and she would say I'm fine, and her daughter would say, "Tell her the truth."

Q. Well, what treatments did her daughter not want Mrs. Reynolds to have as you heard them in interacting with them?
A. This was over a long period of time, sir. I don't recall exactly all the details.
Q. So, you don't remember any specific treatment that Mrs. Reynolds' daughter did not want her to have?
A. Nothing in particular.
DR. MITTLER: Let me see here. Let me hand you what's been marked -- Let's see here. I'm going to mark this as Exhibit 3.
MR. WOOLSEY: Thank you.
(Exhibit 3 was marked.)
Q. (By Dr. Mittler) I'm going to hand you what's been marked Exhibit 3, which are some laboratory reports from Mrs. Reynolds' records. And, again, these do not have Bates stamps on them. They're three different laboratory reports on Mrs. Reynolds, from her initial evaluation in November of 2015. Do you see those?
A. Yes.
Q. Now, take a moment to look through them. Have you seen these before?
A. I've seen the first page before.
Q. You haven't seen the other pages?

A. I don't -- I have not seen this page.
Q. Do you want to take a moment -- Would these records be in a specific part of your paper records?
A. Sure.
Q. Is there -- Is there a laboratory section?
A. Yeah.
Q. Do you want to take a moment to look through those pages and confirm that these are there.
A. I have -- Oh, sorry. I only have this.
Q. Okay. So, let's see. You have this. And let me look at this page. Okay.
So, these are the pages that you have; is that correct?
A. Yes, sir.
Q. You only have the first two pages; is --
A. Yeah.
Q. -- that correct?
A. Yeah.
Q. All right. And that -- And I'm going to ask you.
And the pages you have have writing on them; correct?
A. Uh-huh.
Q. All right. Now, I'm going to represent to you that this is -- that the page -- Exhibit 3, the

first two pages are pages that were produced in the time period of around the first part of July of 2018, and they have no writing on them.
MR. WOOLSEY: Produced by who?
DR. MITTLER: Mrs. Reynolds' daughter. Okay.
Q. (By Dr. Mittler) And they have no writing on them. Was there ever a time when that piece of paper -- well, do you recall when you put the handwriting on Exhibit -- Exhibit 3 has no handwriting.
The same page -- first page of Exhibit 3 in your records has handwriting on it; correct?
A. Yeah.
Q. All right.
A. And this is my assistant's handwriting.
Q. That's your assistant's handwriting. And some of the handwriting is -- Is all of the handwriting by your assistant?
A. No. This is mine.
Q. So, can you -- can you hold that up to -- the piece of paper from your record, can you show that. Which is your handwriting?
A. This (pointing) is mine.
Q. Okay. And what about the ink, are those initials on the other side of the page?

A. No. She wrote "not ready".
Q. Okay. But what about the initials -- I'm sorry -- at the bottom of the other side? Do you see that? They're sort of -- Are those initials?
MR. WOOLSEY: Right here (pointing)?
DR. MITTLER: No. On the other side.
A. It says "11/18 sent -- not ready".
Q. (By Dr. Mittler) Below that there's another ink mark. Do you see that?
A. That's just a --
Q. What is --
A. -- signature.
Q. Okay. Whose signature?
A. Mine.
Q. Can you show that.
A. (Witness complies.)
Q. So, that's your signature; is that correct?
A. Yeah.
Q. All right. When did you write in the black ink on that piece of paper?
A. I don't recall.
Q. Was it done at the time you first saw Mrs. Reynolds?
A. Not when I first saw her.
Q. Was it done after this lawsuit was filed?

A. No.
Q. You can put this down.
A. (Witness complies.)
Q. All right. What does that -- what do those, your -- can you tell us -- well, let me just -- let's make it a little bit -- We have Exhibit 1.
DR. MITTLER: Bill, would it be okay if I just made Exhibit 4 this piece of paper?
MR. WOOLSEY: Yes.
DR. MITTLER: Do you see what I mean?
MR. WOOLSEY: Yeah.
DR. MITTLER: And then we can refer to Exhibit 4.
MR. WOOLSEY: Yeah. I just want to make sure we can -- yeah, because I don't want to get --
DR. MITTLER: Yeah.
MR. WOOLSEY: -- what we've marked as Exhibit 1 --
DR. MITTLER: Yeah.
MR. WOOLSEY: -- mixed up.
DR. MITTLER: Well, let's just mark this as Exhibit 4. Okay? I'm going to mark this as Exhibit 4.
MR. WOOLSEY: Somebody is going to have to help Debbie get everything back to her car.

(Exhibit 4 was marked.)
Q. (By Dr. Mittler) Okay. So, we've marked Exhibit 4, and that's -- do you agree that that's a copy of the page from your record? Is that right? Could you hold up Exhibit 4 and also the page from your record and just show that they're basically the same; is that correct?
A. (Witness complies.)
Q. They're the same. All right.
Now, if you'll now look at Exhibit 4. There's a -- In your handwriting it says 12/15, verbal negative. Do you see that?
A. Uh-huh.
MR. WOOLSEY: You've got to say "yes" or "no".
Q. (By Dr. Mittler) And that's by your assistant, not you, or is that by you?
A. This (pointing) is my handwriting.
Q. Okay. So, you -- So, what's written, 12/15 verbal negative, what does that mean?
A. I don't exactly recall what that means right now, sir.
Q. And you don't know when you made that annotation to the record; is that correct?
A. So, what happens is my assistant usually

calls and tries to get all the information that's lacking. So, it looks like she had written there that it was not ready, and then I've written here that there was insufficient tissue and to get a copy.
Q. All right. And you wrote there was "insufficient tissue for EGFR". Is that correct?
A. That's what it looks like, yes.
Q. All right. And had you gotten -- did the -- Did you ever attempt to get an EGFR determination on Mrs. Reynolds' lung tissue?
A. So, you know, these tumor markers are all, like, evolving, so every so often we have something new that would come up. Like, for example, there's PD-L1. Then there is ROS. There is BRAF. So --
Q. So, what -- What was the second one? The se- -- One was PD-L1. And what --
A. PD-L1.
Q. -- was the second one? I'm sorry.
A. Then there is ROS.
Q. That's capital R-O-S?
A. Uh-huh.
Q. And?
A. BRAF.
Q. B-R-A-F?
A. Uh-huh.

Q. Okay.
A. And then there is something called MSI-H. Then there is EGFR. Then there is ALK.
Q. That's A-L-K?
A. Uh-huh.
Q. Those are all capitals; right?
A. (Witness nods head up and down.)
Q. Okay.
A. So, there, you know -- So, for example, for breast cancer there is, you know, a set of things we look for -- ER, PR, HER2, lymph node, things like that.
For lung cancer, it seems like something new comes up every six months. So, it's hard to remember, you know, what was step -- you know, what was done at that time. We called to ask if prognostic markers were done.
Q. Why are prognostic markers important?
A. It would give the patient eligibility for more options.
Q. And those options have to do with targeted treatment; correct?
A. Not always. Sometimes it could be just a hormone blocker.
Q. Now, in lung cancer, two markers are particularly important; aren't they?

A. There's numerous markers that are important.
Q. Well, would you agree that the two genetic markers that are noted in both Exhibit 3 and Exhibit 4, namely the ALK and EGFR markers, are important in selecting the correct treatment for patients with lung cancer like Mrs. Reynolds?
A. So, there is a PD-L1, that that one is also important. Actually, that one has so much more implication because these are very rare. ALK and EGFR are rare.
THE REPORTER: I'm sorry. These are very rare...
THE WITNESS: Rare aberrations.
DR. MITTLER: I'm going to object as nonresponsive.
Q. (By Dr. Mittler) My question is, are the ALK and EGFR genetic markers that are noted in the pathology report on Mrs. Reynolds that was collected on November, it looks like 16th, 2015, are those markers important for selecting appropriate therapy for the lung cancer that Mrs. Reynolds had?
A. So, there are numerous things that we try to obtain on the tumor marker which will give more options for the patient.
Q. Is the answer to my question yes?

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A. I don't completely agree with your question.
Q. Would a oncologist -- hematologist/oncologist seeing Mrs. Reynolds in November of 2015, would a -- would that oncologist, exercising ordinary prudence, take into account the status of the ALK and EGFR markers in designing and selecting appropriate therapy for lung cancer in a patient like Mrs. Reynolds?
A. So, these -- these targeted, you know -- So, the PD-L1 is much more important than these two because that's the most common one that we have therapies against.
Q. Are you aware of any guidelines that indicate that a patient, who was staged as you staged Mrs. Reynolds in November of 2015, should have had treatment that was tailored to her -- either her EGFR or ALK marker status as a -- in deciding first-line therapy? Are you aware any -- aware of any guidelines that say that?
A. We follow NCCN guidelines and --
Q. And what is the NCCN?
A. National Comprehensive Cancer Network.
Q. And what's the importance of NCCN?
A. They're just a broad range of guidelines, and we take that and try to customize somebody's treatment. They are just guidelines.

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Q. They're not the -- Do they have some meaning for the standard of care in treating patients like Mrs. Reynolds?
A. Sure, yes, standard of care.
(Exhibit 5 was marked.)
Q. (By Dr. Mittler) I'm going to hand you what's been marked Exhibit 5. Dr. Rao, this -- I've marked as Exhibit 5 two pages of a quick guide for "Non-Small Cell Lung Cancer" published by the National Comprehensive Cancer Network. It says Version 1.2015. Do you see that at the top?
A. Yes.
Q. Have you seen this guideline before?
A. Not this 1.215 [sic], but we follow NCCN guidelines.
Q. And do you agree that Mrs. Reynolds had non-small cell lung cancer when you first saw her?
A. Yes.
Q. All right. And do you agree that you staged her as Stage IV?
A. Yes.
Q. Okay. And if you would turn to the second page, do you see where that section says, "What are the options for widespread Stage IV?" Do you see that?
A. Uh-huh.

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Q. And do you see that the NCCN has a table for guiding therapy? The first option is abnormal EGFR. Do you see that?
A. Yes.
Q. And the second one is abnormal ALK?
A. Yes.
Q. And the third is known or unknown EGFR or ALK status, correct?
A. Normal or unknown, yes.
Q. Do you see that?
A. Uh-huh.
Q. So, my first question is this. Is this guideline -- Does this indicate that the NCCN believes that knowing the EGFR or ALK status is important for selecting therapy for Stage IV lung cancer like Mrs. Reynolds had?
A. So, like I was trying to talk to you, sir, there are other -- other tumor markers as well, which is not here. So, I don't know how they can be missing from this page, like PD-L1 or ROS or BRAF.
So, they have -- usually we have to have -- you know, if somebody is able to get that kind of information, that would be good, too, so we can, you know, have more options for patients' treatment.
Q. Well, the NCCN didn't list, on this two-page

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quick guide in 2015, PD-L1 for making the initial treatment decision; did they?
A. Well, I don't know where you got it from, but PD-L1 was already well -- you know, the -- aware at that time.
Q. So, is it your testimony that the EGFR and the ALK status were not the critical tumor biomarkers that were necessary to make an initial treatment decision on Mrs. Reynolds in November of 2015?
A. I would say that there are many things that one has to look at. And if they're available, that gives them another choice.
Q. The ALK status was known on Mrs. Reynolds in November of 2015; wasn't it?
A. I didn't know.
Q. But it -- My question is, the ALK status was known on Mrs. Reynolds in November of 2015; wasn't it?
A. I can't answer that question because I didn't know.
Q. Well, haven't you learned subsequently that the ALK status was determined in November of 2015?
A. Yes. I -- I learned that subsequently.
Q. And when did you learn that?
A. When I got paperwork from Mr. Powell's office.

Q. So, the first time you learned that the ALK status was positive is when you received notice of this lawsuit; correct?
A. Yes.
Q. But at the time you made a notation on Exhibit 4 in your records, you also knew that the EGFR status was not known; correct?
A. Sir, this happened so long ago, all I can tell you is my assistant had called and she's written here "not ready". I've written here there was "insufficient tissue". So, that's all I can tell you, sir. I don't remember. It was five years ago.
Q. Well, have you read Dr. Stephen Cohen's expert report in this lawsuit?
A. Stephen -- stephen Cohen's expert report?
Q. Yes, in this lawsuit.
A. I have read his paperwork, yes.
Q. Do you know who Dr. Cohen is?
A. I've heard of him.
Q. Have you ever worked with him?
A. No.
Q. Okay. Have you -- Have you heard that he's an oncologist in the community, of good reputation?
A. I know he's an oncologist.
Q. You've seen his multiple criticisms of your

treatment of Mrs. Reynolds; is that correct?
A. I have read through them, yes.
Q. Okay. And in fairness, we're going to go over these in detail, but do you recall that one criticism is that you initiated therapy, on Mrs. Reynolds with her lung cancer, without knowing the ALK or EGFR status of her tumor? Do you recall that that's one of his criticisms?
A. Well, any oncologist who wants to help a patient will initiate treatment. That is standard of care. You don't wait for mutations and all that. You know? You just start treatment when somebody is sick.
Q. But you -- But it's important to start treatment with the right drugs; correct?
A. What treatment she got was the right drug for her.
Q. So, it's your testimony that you were right to start the -- the chemotherapeutic agents you did without knowing the ALK or EGFR status of her tumor; is that correct?
A. Yes.
Q. Do you also agree that the ALK and EGFR status of her tumors were knowable at the time you initiated treatment?
A. I did not know that.

Q. Well, going back to Exhibit 4 from your record, do you see -- Can you look at Exhibit 4, please, Dr. Rao. Do you see it says "ALK AND EGFR TESTING: IN PROGRESS; ADDENDUM TO FOLLOW"?
A. And it says "discussed with Dr. Gomez".
Q. Yes, but -- but did you initiate any call on your own, at any time you took care of Mrs. Reynolds, to find out what her ALK status was?
A. I called and -- It looks like I called and spoke to the pathologist and this is what we were told.
Q. And who -- Which pathologist did you talk to?
A. It was a woman. I don't -- They have had a lot of people come and go at Baptist. I don't remember exactly.
Q. And the pathologist told you what?
A. I have written here that "insufficient tissue".
Q. Did you -- Did you order a new test for the EGFR?
A. Sir, when they say there's insufficient tissue, how can I order new tests?
Q. Well, you could have ordered a test to get more tissue to do the EGFR test; correct?
A. So, I don't know -- Mrs. Reynolds, I know you know her history. She has had three or four biopsies

by the time she came to see me in December of 2015, and she has had numerous nondiagnostic tests. And by the time she came to see me, she was very anxious, desperate, wanting to start treatment. So, getting another tissue biopsy was out of the question. We already know it's an adenocarcinoma, so I -- I knew what I needed to start her therapy.
Q. Well, the standard of care from the NCCN that we have says that you needed to know the -- either the -- you needed to know both the EGFR status and the ALK status, both genetic tumor markers, to select the correct therapy; isn't that true?
MR. WOOLSEY: Objection; form. You can still answer. I'm just objecting for the record. You can...
A. So, the standard of care is also to the know the ROS status, PD-L1 status, BRAF, all of them.
Q. (By Dr. Mittler) All right. Did you obtain any of those on Mrs. Reynolds?
A. When they say there is not enough tissue, there is no way to obtain anything.
Q. So, you've mentioned PD-L1. Did you ever obtain the PD-L1 status on her?
A. When they say there is not enough tissue, there is no way to get any other further testing.

Q. So, the answer to that is no --
A. There was not --
Q. -- correct?
A. -- enough tissue I was told.
Q. So, if treating a patient with a -- well, first of all, you do advertise on your website that you offer targeted therapy; correct?
A. Yes.
Q. What does "targeted therapy" mean?
A. Targeted therapy -- so, for example, breast cancer, if somebody had HER2+, we would give a drug called Herceptin.
Q. Well, what about in lung cancer, what does targeted therapy mean?
A. So, lung cancer treatments have been evolving. So, when I was first in my fellowship, there was carbo, Taxol, Gemzar, etoposide. That's it. So, every six months there seems to be something new coming out, so we have to also look at it in that time frame.
Q. Well, in 2015, it was well-known that a lung cancer patient like Mrs. Reynolds, who had a positive ALK genetic rearrangement, would do best with a drug called crizotinib; isn't that correct?
A. It doesn't say that. All it says is, if you have a target -- if you have a mutation, you have,

you know, the ability to help the patient with another -- with another drug.
Q. Are you -- have you seen Dr. Conde's -- Well, first of all, do you know who Dr. Conde is?
A. I know of her.
Q. Have you looked at her records pertaining to Mrs. Reynolds?
A. Yes.
Q. And did you look at the first visit of Mrs. Reynolds to Dr. Conde?
A. I read -- I have looked at it, yes.
Q. And that occurred sometime in early July of 2017; is that correct?
A. Yeah.
Q. All right. And do you recall that one of the first things Dr. Conde did was to determine Mrs. Reynolds' ALK status?
A. I don't know what she did first and what she did second. I don't know, sir.
DR. MITTLER: I'm going to just hand you -- I'm going to make this -- I just didn't bring extra copies, but I'm going to hand you the --
(Exhibit 6 was marked.)
DR. MITTLER: -- July 6th initial visit of Mrs. Reynolds to see Dr. Conde.

Q. (By Dr. Mittler) Have you looked at that visit before?
MR. WOOLSEY: Does that have a page number on it?
A. I read through it.
Q. (By Dr. Mittler) Yeah. Do you agree that Dr. Conde emphasizes the ALK status of Mrs. Reynolds' tumor?
A. So, Dr. Conde writes here that she had called and she got the pathology report, and she wrote here that "EGFR and ALK gene rearrangement was ordered, but it was subsequently reported as an addendum." That's what she writes.
Q. Right. And she also reports that it was -- the ALK biomarker was positive; correct?
A. Yeah, she had that information.
Q. And it's also true that all the time you treated Mrs. Reynolds from November through June of 2017, that you never called and got the actual result of the ALK marker determination; isn't that true?
A. I did call, and I was told there was not enough tissue.
Q. Well, you were told that -- The report says there was not enough tissue for the EGFR, but the ALK status was determined; correct?

A. I didn't know that.
Q. But it was knowable; correct?
A. I can't answer that question, sir.
Q. Well, Dr. Conde was able to -- to get --
A. Because --
Q. -- that information; correct?
A. -- by the time she called --
Q. Correct?
A. What correct, sir? What -- What is correct, sir?
Q. The ALK marker -- the EGFR st- -- The insufficient tissue referred to the EGFR marker, not to the ALK marker?
A. I can only go by what I've written here. That was five years ago. And I was the first doctor to see the patient. When I called the pathologist, this is what was told, and I initiated appropriate treatment for Mrs. Reynolds. She responded well to the treatment, and she, you know, did well on various therapies till 6/2017.
Q. You did not get the ALK status because you did not call subsequent to your initial conversation, to see if the ALK had been completed; correct?
A. I had called and talked to the pathologist, and I was told that there was insufficient tissue. And

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I also wrote here something like verbal negative. I don't know what that means.

But I initiated treatment, and my patient did well. So, I didn't know that there was an ALK mutation out there.

Q. Would it have been important to know --

A. Not really.

Q. -- the ALK mutation?

A. Not really.

Q. Well, that was my next question.

So, it's your testimony that you really didn't need to know the ALK mutation status to treat Mrs. Reynolds; is that correct?

A. It's a very -- It's a very rare mutation, and it's only in 3 percent of lung cancers. So, Avastin is only approved for front-line. So, when somebody has Stage IV cancer, they only have so many drugs that you can use, so you have to go with what is front-line which you can use. If you don't use, you lose.

So, if you have six or seven drugs approved for a particular cancer and you don't use which is first-line therapy, you cannot go back and use it after two years. So, my job is to help my patient get maximum control of disease and live the longest, so I chose Avastin which is only approved front-line.

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Q. You agree that the NCCN guideline on -- that you have before you in an exhibit says that, with an abnormal ALK, the first-line drug is crizotinib? Do you agree with --

A. No, I did not agree with that.

Q. So, you don't agree with the NCCN guideline?

A. But it doesn't say that, sir. So, NCCN guidelines are just guidelines. You have to -- You have to take that and come up with a treatment plan for your patient that best suits them.

Q. Well, what --

A. NCCN doesn't say you have to give crizotinib for front-line. It doesn't say that.

Q. Well, what is your basis for disagreeing with the NCCN guideline of crizotinib being the first treatment for a patient with non-small cell lung cancer, like Mrs. Reynolds, with an abnormal ALK genetic marker?

A. So, non-small cell lung cancers have many types. There's adenocarcinoma. There's squamous carcinoma. Then there's large-cell and neuroendocrine. There are different types of non-small cell lung cancers.

So, when you pick anything that's non-squamous -- so you have to go with what drugs are -- the patient is eligible to receive. And then you have to see what will the patient lose out if you don't do front-line or second-line or third-line. So, that's how we come up with a treatment plan.

Especially when I didn't have enough tissue to run tests, we -- we treated appropriately for adenocarcinoma. She responded. All the subsequent scans show that. And I think everything was done appropriately.

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Q. Now, you said that the ALK-positive marker is rare in non-small cell lung cancer; correct?

A. Yes.

Q. You gave the number, three percent; correct?

A. Three to four percent, yeah.

Q. But do you also agree that even though it's a rather small percentage, that Mrs. Reynolds, in fact, had it? Correct?

A. I didn't know that until later.

DR. MITTLER: I'm going to object as nonresponsive.

Q. (By Dr. Mittler) My question is, even though it's relatively rare, the ALK marker in non-small cell cancer, in fact, Mrs. Reynolds had that genetic marker at the time you first saw her and all the time you treated her; correct?

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A. It appears to be so.

Q. In other words, just so the jury understands, this is not a marker that developed later sometime in her lung cancer, right, after you saw her? Is that correct?

A. Yes. It didn't develop.

Q. Yeah. She had it at the beginning of her lung cancer, and she had it throughout the course of her lung cancer; correct?

A. Right.

MR. WOOLSEY: When you get to a shift point, I'd like to take a break. We've been going about an hour.

DR. MITTLER: Okay. We can --

THE VIDEOGRAPHER: Going off the record --

DR. MITTLER: -- do that.

THE VIDEOGRAPHER: -- at 11:03.

(Recess.)

THE VIDEOGRAPHER: We are back on the record at 11:15.

Q. (By Dr. Mittler) Okay, Dr. Rao. We're back on the record, and you're still under oath. Do you understand that?

A. Yes.

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Q. All right. So, we've marked as Exhibit 6 four pages from Dr. Conde's medical records that are the record of the first visit of Mrs. Reynolds to see Dr. Conde on July 6, 2017. Do you -- Do you see that?
A. (Witness nods head up and down.)
Q. And those are the records you just looked at; correct?
A. Yes.
Q. And if you would turn to page four of those records, I think there is actually a "4" on the bottom right of that page. Do you see that?
A. Yes.
Q. And do you see under Impression/Plan that Dr. Conde wrote "Patient with ALK positive adenocarcinoma of the lung with evidence of progression of the disease after two lines of therapy that included carboplatin, Alimta and followed by Opdivo"?
A. Yes.
Q. Do you see that?
A. Uh-huh.
Q. So -- And then do you see the three lines from the bottom where she said, "I recommend treatment with crizotinib"?
A. Uh-huh.
Q. Do you see that?

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A. (Witness nods head up and down.)
MR. WOOLSEY: You've got to go "yes" or "no" for the sake of the record.
A. Yes, I see that.
MR. WOOLSEY: All right.
THE WITNESS: Sorry about that.
MR. WOOLSEY: It's the "uh-huh" that --
THE WITNESS: I'm sorry.
MR. WOOLSEY: That's --
THE WITNESS: I know the --
MR. WOOLSEY: It's natural speech.
THE WITNESS: Sorry.
MR. WOOLSEY: I'm not picking on you.
THE WITNESS: Just nudge me.
DR. MITTLER: Thank you, Bill.
Q. (By Dr. Mittler) Okay. So -- Now, do you also see that Dr. Conde had noted that Mrs. Reynolds had been on hospice? Correct?
A. Yes.
Q. Well, first of all, do you agree that the -- that the treatments that you had Mrs. Reynolds on had -- in spite of her being on them, had been associated with progression of disease? Do you agree with that?
A. No, I don't.

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Q. So, you don't think Mrs. Reynolds' lung cancer disease progressed under your treatment?
A. Not -- Over a period of time.
Q. Yes or no?
A. Over a period of time.
Q. Is the answer yes?
A. She progressed when she had a PET scan done in May 2017, yes.
Q. Okay. I'm sorry. I'm still not clear.
Is the answer yes, it did progress over a period of time or no, it didn't progress over a period of time?
A. Yes, it progressed over a period of time.
Q. And you last saw Mrs. Reynolds on or about June 2, 2017; is that correct?
A. I can check. Yes, June 2, 2017.
Q. And Mrs. Reynolds went into a hospice shortly after that; correct?
A. Per her family's wishes.
Q. And did you -- Well, wasn't it your assessment that she wasn't doing well and hospice was appropriate for her?
A. It was my assessment that she wasn't doing well.
Q. Did you certify her for hospice?

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A. I'm not sure who certified her, but her family wanted her to consider comfort measures.
Q. Was the -- Was putting her in hospice in June of 2017 appropriate?
A. It was appropriate at that time, yes.
Q. And going into hospice means that a patient has six months or less to live, right?
A. Not always.
Q. Let me say it again. Going into a hospice, for a Medicare patient, means that a doctor has to certify that a patient has six months or less to live; correct?
A. That's what I've heard of, yes.
Q. And, in fact, Mrs. -- Do you know when Mrs. Reynolds died?
A. Not the appropriate -- I mean not the exact date, but I think she passed away last year.
Q. Okay.
A. Or earlier in 2019.
Q. All right. I'm going to represent to you that Mrs. Reynolds died in 2019.
So, in fact, Mrs. Reynolds lived almost two years after she was certified as being a terminal patient; correct?
A. I didn't certify her to be -- I didn't

certify the hospice.
Q. Well, your assessment of Mrs. Reynolds' prognosis was not correct as of June 2, 2017; correct?
A. My assessment of?
Q. Of Mrs. Reynolds' prognosis was not correct as of June 2, 2017; correct?
A. Can you elaborate on that. I don't understand.
Q. Was your assessment of Mrs. Reynolds' prognosis accurate as of the last time you saw her?
A. So, when I saw her the last time, we had a family meeting. So, her son was there, her daughter, and her husband. So, I talked to them about the PET scan, and I said that, you know, there are new lesions. And she was also not feeling very well, and her son wanted her to go on hospice.
So, I told them that, you know, she's not going to be -- you know, she's not going to do well on chemotherapy, and we had tried immunotherapy, which is Opdivo. So, I -- When her son said that, I said I will definitely help get a hospice company to talk to you.
Q. So, did you have a different assessment of Mrs. Reynolds' prognosis on June 2, 2017 that is indicated in your medical records?

A. So, her PET scan showed that she had progressed and she was also not feeling very good. Every week, you know, she was getting more anxious and tired, and lots of conflict in the family.
So, the same thing happened on that day when I asked Mrs. Reynolds, "How are you feeling?"
She said, "I feel good," or "I feel fine."
And her son yelled at her, and he said, "You're not feeling good. You don't say that to the doctor."
Q. So, it's your testimony that her son yelled at her; is that correct?
A. Yes.
Q. And what did he want her to do?
A. He wanted her to stop treatments.
Q. Do you know, from looking at Dr. Conde's records, that in fact Mrs. Reynolds did get crizotinib treatment under Dr. Conde's care?
A. Yes, in 2018.
Q. So, Dr. Conde gave her the treatment that the NCCN guidelines called for in 2015; correct?
MR. WOOLSEY: Form. You can answer.
A. Sir, Dr. Conde after one year -- after her first visit, I know Mrs. Reynolds went back to see her

in 2018, and she gave her the crizotinib.
Q. (By Dr. Mittler) And Mrs. Reynolds lived approximately two years after you last saw her; correct?
A. So, when -- When did Mrs. Reynolds pass away, sir?
Q. Okay. For the record --
A. What date?
Q. I'm going to represent to you that Mrs. Reynolds died on May 6, 2019.
A. Okay.
Q. And you last saw Mrs. Reynolds on June 2 --
A. In June 2017.
Q. -- 2017 --
A. Yes.
Q. -- correct?
A. Yes.
Q. So, Mrs. Reynolds, in fact, died --
MR. WOOLSEY: Don't talk over each other.
Q. (By Dr. Mittler) Mrs. Reynolds, in fact, died approximately 23 months after you last saw her; correct?
A. Yes.
Q. And the only treatment she had during that

time was crizotinib; correct?
A. Can you please tell me -- To answer that question, I would like to know how many months she took the crizotinib.
Q. Well, we'll talk about that. I get to ask the questions, okay, at this -- at this point.
A. No, but you're asking me to tell you that -- you are telling me she lived for two years.
MR. WOOLSEY: He didn't ask you a question. He didn't ask you a question.
DR. MITTLER: There's no question on the table for you, Dr. Rao. That's just the way the deposition works.
Q. (By Dr. Mittler) The -- Let's go back to the -- your decision about Avastin. One of the first anticancer drugs you prescribed was Avastin; correct?
A. Yes.
Q. And Mrs. Reynolds got one dose of Avastin; correct?
A. Yes.
Q. And then she got a complication; correct?
A. Uh-huh, yes.
Q. And what was -- What was the complication?
A. She had diverticular abscess.
Q. And, in fact, she had a bowel perforation;

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correct?
A. Which was limited.
Q. Is that the answer yes?
A. Yes.
Q. And you know that Avastin has a black box warning about intestinal perforation; correct?
A. Yes.
Q. And, in fact, you've seen in Dr. Cohen's report that he's criticized you for prescribing Avastin in someone like Mrs. Reynolds who had had recent diverticulitis and diverticular disease; correct?
A. When I saw Mrs. Reynolds, she did not have diverticulitis.
Q. But you knew she had a history of recent diverticular disease; correct?
A. She has a history of it.
Q. You noted that in your records; correct?
A. I don't know. I have to look at my notes.
Q. Okay. I'm going to have to -- in the interest of time, I will -- we'll provide that record to you, but I'm going to represent to you that you did note that she had a history of diverticular disease. And we'll find that record.
But let's -- assuming that you noted diverticular disease, are you aware that there are --

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that there are articles in the medical literature that say that diverticulitis is a relative contraindication to prescribing Avastin?
MR. WOOLSEY: Form.
Q. (By Dr. Mittler) Are you aware of that?
A. If they -- someone has active diverticulitis, you don't prescribe Avastin.
Q. But, in fact, Mrs. Reynolds had got in fact an intestinal problem within 30 days of your giving her Avastin; correct?
A. She did get -- She had a problem, yes.
Q. And that caused you to stop the Avastin; correct?
A. Yes.
Q. Now, you also started Mrs. Reynolds on carboplatin; correct?
A. Uh-huh.
Q. And what else? What other drugs did you start Mrs. Reynolds on in -- on or about November, early December 2015?
A. Avastin and a very low dose of carboplatin.
Q. And she had an allergic reaction to carboplatin; correct?
A. After three or four months, yeah.
Q. And so, you had to stop that; correct?

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A. Yes.
Q. And what did you put her on?
A. Cisplatin.
Q. And what is cisplatin?
A. It's a cousin of carboplatin.
Q. And is that a platinum-containing --
A. Uh-huh.
Q. -- anticancer drug?
A. Yes.
Q. And one of the complications of platinum-containing anticancer drugs is something called neuropathy; correct?
A. Yes.
Q. And what is neuropathy?
A. Neuropathy is tingling, numbness of hands and feet.
Q. Well, you're describing what's called sensory -- the sensory part of the nervous system; correct?
A. Yes, the sensory neuropathy.
Q. But you also can get -- patients can get motor neuropathy, too, from platinum; correct?
A. They can, yes.
Q. And Mrs. Reynolds in fact got that; correct?
A. I don't think so.

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Q. So, you -- do you -- Did you document neuropathy in Mrs. Reynolds' medical records while she was under your care?
A. She had very mild peripheral neuropathy.
Q. She also had an abnormal gait and inability to walk, ultimately requiring her to be in a wheelchair; isn't that correct?
A. Not when she was under my care.
Q. And so -- And, in fact, the neuropathy caused by platinum can be permanent; correct?
A. Some people it can be permanent.
Q. And Dr. Cohen in his report says, in fact, the platinum -- the cisplatin that you gave in fact caused her peripheral neuropathy, particularly the motor component. Did you read that part of his report?
A. You know, he wrote a lot of things, sir. Yes.
Q. Do you -- Do you agree with it?
A. No, I don't.
Q. Why do you disagree with it?
A. Because, number one, Dr. Cohen doesn't know how ma- -- what is the milligrams of any of these drugs the patient received. So...
Q. Okay. And why are the milligrams important?
A. Because she got a very low dose.

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Q. Of cisplatin.
A. And carboplatin.
Q. Okay. And is there a certain dose of cisplatin that somebody gets that can be associated with neuropathy?
A. Well, neuropathy doesn't just come from chemotherapy drug alone. If somebody has had the comorbid conditions, like diabetes, or they're frail and they're old, like over 80 years of age, you know, there are so many other things that can cause -- or if they're on medications, other medications. So, they can all contribute to a cumulative toxicity.
Q. Do you know how many milligrams of cisplatin that Mrs. Reynolds received?
A. She got less than 15 milligrams per meter square.
Q. Do you know what her cumulative dose was?
A. I don't have the number right now, but we can figure it out.
Q. Okay. I'm going to help you in a minute.
Do you know what -- Do you know any articles in the literature that associate peripheral neuropathy or nerve damage with a certain amount of cisplatin milligrams per meter squared?
A. I don't have -- you know, I can't cite an

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article right now, but neuropathy can be associated with certain drugs, yes.
Q. Are you aware that articles have been written in the oncology medical literature that look into the association between the amount of milligrams given per meter square and neuropathy in patients like Mrs. Reynolds?
A. If you show me the article, I can tell you whether I've seen it.
Q. Okay. I will in a moment.
The -- how many meters square -- What does the term "meters square" refer to?
A. It's called BSA. So, it's based on height and weight of a patient.
Q. So, is it your testimony that body surface area is meters squared?
A. Body surface area is what we use to calculate doses of chemotherapy drugs.
Q. Do you know how many meters squared Mrs. Reynolds was?
A. She was different meters squared at different times.
Q. Okay. When you first saw her, what was her height and weight?
A. I'll have to go back and look in the chart.

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Q. Okay. Well, I'm going to represent to you that she was 138 pounds and listed at 65 inches. Do you recall that?
A. I can look and tell you.
Q. Okay. See if I'm correct. Could you do that?
A. So, it says 65 inches, 138.7 pounds, BSA 1.69.
Q. Okay.
(Exhibit 7 was marked.)
Q. (By Dr. Mittler) I'm going to hand you -- I'm going to hand you what's been marked Exhibit 7, and this is my own calculation taken from your records. And, you know, I'm sure Mr. Woolsey will object and you-all can do your own calculation, but this is a running total of your cisplatin dosages taken from your billing records.
MR. WOOLSEY: He's right. I'll object. It is his -- just his tabulations. We'll reserve the right to point out any errors if any exist.
DR. MITTLER: Okay.
Q. (By Dr. Mittler) My question to you: Are these numbers to you -- does this represent a high or low dose of cisplatin per body surface area in Mrs. Reynolds?

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A. Low.
Q. So, at no time -- do you know what the -- what any cutoff point is for toxicity, neurotoxicity for cisplatin per meters squared?
A. It's different in different people.
Q. Okay. So, in treating Mrs. Reynolds, were you -- were you aware or keeping a running total on the amount of cisplatin you were giving -- giving to her in terms of a -- avoiding a particular toxicity dose?
A. So, it's not something that you just look at on paper. You have -- We talk to the patient. You know, it's a cli- -- so, for example, there's Taxol, right? There are some people who cannot take even eight weeks of Taxol, but I have a patient, not one but five, they have been on Taxol for five years. So, everybody is different.
That's why we talk to the patient and we find out how they are doing before or after, you know, to stop the medication, which we did once she said that she was feeling weak. We stopped it although she was responding to the therapy.
Q. You stopped the cisplatin; is that correct?
A. We stopped whatever treatment, the Alimta, whatever she was on, despite her scans looking stable because then we started her on Opdivo --

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Q. Well, you --
A. -- based on somebody's -- like, her clinical symptoms.
Q. Well, you agree that -- Do you agree that her weakness was in part due to her neuropathy?
A. I don't agree.
Q. What was her weakness due to?
A. She had many things that contributed to her weakness. She was extremely anxious. She was debilitated. She was not walking about. She wasn't pushing herself, you know, to be well. We spent a lot of time every week trying to motivate her to get better.
Q. Did you read her deposition in this case?
A. No, I did not.
Q. Well, I'm going to represent to you that Mrs. Reynolds has -- has said that she -- one of the things she lost was her ability to use her hands well.
Do you agree that that inability to use your hands well is a -- is a function of peripheral neuropathy?
A. I don't know what exactly was said, but we have all our documentation about her -- what she was in December and later in the year. And we also have physical therapy, you know, that went out. And we have

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all of those documentation, as well.
Q. Now, you -- You staged Mrs. Reynolds as Stage IV on the first day you saw her; correct?
A. Yes.
Q. And what was the basis -- tell -- Tell the jury what Stage IV means.
A. Stage IV in lung cancer could be if tumors were in two different parts of the lung, which was in her case left upper lobe and the right upper lobe.
Q. And how did you know that Mrs. Reynolds had tumor in her right upper lobe?
A. Given the historic information from April to December.
Q. Well, in April of 2015, the biopsy was negative of the up- --
A. It was negative of the left lung, too.
Q. Okay. Let me finish my question.
In April of 2015, the biopsy of her right upper lobe was negative for cancer; is that -- isn't that true?
A. That is true.
Q. All right. Between April of 2015 and November of 2015, when you first saw Mrs. Reynolds, there was no evidence developed of any tumor in the right upper lobe; was there?

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A. So, she had persistent lesions in her scans. And so, in Stage IV cancer, we don't go and -- we don't need tissue diagnosis of every lesion in the body. If we have one lesion that shows cancer, we go with corroborative evidence that -- you know, that all the other lesions are cancerous, too.
Q. Well, the radiologist, in fact, did not read the right upper lobe lesion as being indicative of cancer, did the radiologist?
A. The radiologist read it as neoplastic inflammatory on both sides. He said it could be this and it could be that.
Q. Okay. Let's look at that. Can you show me that.
A. Sure.
THE WITNESS: Mr. Woolsey, we had that scans, you know, as a pile. Here, this one.
Q. (By Dr. Mittler) Which imaging report are you looking at?
A. So, there is a PET scan from 10/2/2015.
Q. Okay.
A. So, it says left upper lobe masslike opacit- -- opacity. Could be infectious, inflammatory, and/or neoplastic. Then it says right upper lobe chronic consolidation. Could be chronic infectious,

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inflammatory, or neoplastic.
Q. So, neither of those reports say that it's definitively neoplastic; correct?
A. A radiologist is not going to tell us that something is definitely neoplastic. It's common sense and the clinical presentation.
Q. And the "neoplastic" refers to cancer; correct?
A. Uh-huh.
Q. All right. Because we want the jury to understand. We just don't want to talk "doctor talk". All right?
So, "neoplastic" refers to cancer?
A. (Witness nods head up and down.)
Q. Now, would you agree that the -- that the radiologist doesn't say there's definitive cancer with either one of these lesions? Correct? Would you agree?
A. I have to comment about what the radiologist was thinking?
Q. The radiologist didn't say that either one, either the right or the left lung, showed absolutely cancer; correct?
A. No, he doesn't say that.
Q. All right.

A. He gives a broad differential.
Q. So, a month later a biopsy was obtained of the left upper lobe of the lung -- of the left lung; correct?
A. So, let's look at this pathology. What's that biopsy from? The month after?
Q. The biopsy was 11 -- was an 11/16/15.
A. Uh-huh, yes.
Q. And the decision --
MR. WOOLSEY: It's been marked, hasn't it?
DR. MITTLER: Yes.
MR. WOOLSEY: Yeah.
Q. (By Dr. Mittler) A decision was made to biopsy the left upper lobe; correct?
A. It looks like it. I wasn't involved in that decision.
Q. Then Dr. Gomez didn't re-biopsy the right upper lobe; correct?
A. I don't see that.
Q. Because the right upper lobe had been biopsied seven months before; correct?
A. And the left upper lobe.
Q. And the right upper lobe was negative; correct?

A. It was negative for infection, as well.
Q. So, by the way, are you in this -- At trial, are you going to blame the pulmonary doctor, Dr. Hector Gomez, for any of his care of Mrs. Reynolds?
A. Blame? I'm not blaming anybody.
Q. So, you're not going to blame Dr. Gomez for not getting you the ALK marker or the appropriate biomarkers on Mrs. Reynolds; is that correct?
A. No, I'm not going to blame him.
Q. Are you going to blame the Baptist Health System in any way for not getting you the appropriate information about Mrs. Reynolds in your treatment decisions?
A. No.
Q. Are you going to blame a pathologist at Baptist Hospital, who was associated with doing the evaluation of the ALK and EGFR markers, for not getting you the appropriate information on Mrs. Reynolds?
A. I'm not blaming anybody.
Q. Now, if you look at the imaging studies of the right upper lobe, do you see that there was a -- when was the next scan done on Mrs. Reynolds?
A. 4/2016. There's a CT abdomen in between, but that doesn't cover the lungs.
Q. So, the next was one April 29, 2016; is that correct?

A. Yes.
Q. And do you agree that both upper lobe lesions were read as unchanged?
A. It was smaller, a little bit.
Q. Well, do you agree that there was something called more hypermetabolic activity in the left upper lobe lesion of the lung?
A. You mean in the PET scan?
Q. Yes.
A. Hypermetabolic activity doesn't mean anything. It will be hypermetabolic in infection, inflammation, any of that.
Q. So, it's your -- What does the SUV value refer to?
A. It's the -- It's the brightness of the FDG that's attached to the radioactive material.
Q. So, is it your testimony that the hypermetabolic activity and SUV values are not important in diagnosing lung lesions in terms of there being cancer, or not?
A. They are not good tools to make a diagnosis, no.
Q. Well, then why -- Why do the radiologists measure the SUV values in lung cancer?

A. It's a part of the study.
Q. And what is the meaning of -- well, what is -- a part of the study -- Let me go back.
Why is that -- What does the part of the study pertain to?
A. So, when one reads a scan, they have to indicate size of a lesion and then whatever comes with it.
Q. Is there any clinical information in the SUV value for an oncologist?
A. In some cases.
Q. What would it be?
A. In -- you know, in lymphomas we have had, you know, good, like, corroborative evidence. But just because something was not -- SUV wasn't high doesn't mean it wasn't cancerous.
Q. Did you -- Did you notice, in the PET scan reports that were generated on Mrs. Reynolds, that the radiologist referred to something called ground glass densities?
A. Yes.
Q. What is the significance of ground glass densities in lung cancer?
A. So, it could be tumor or it can be sometimes nonspecific.

Q. Can -- Ground glass densities in lung cancer, can they be associated with a particular kind of tumor called bronchoalveolar cancer?

A. It's not pathognomonic of that.

Q. But can it be?

A. I don't know.

Q. And are you aware of medical literature that says that bronchoalveolar cancer with ground glass appearance can be very curable with resection?

A. In a patient with Stage IV cancer?

Q. I'm asking the question. Are you aware of medical literature that has said that patients with ground glass appearance bronchoalveolar cancer can be curable with resection?

A. If somebody has early stage cancer, whether it's bronchoalveolar, whether there is ground glass opacity or not, whether it's squamous, if they had a small lesion which was -- and they are eligible to have a surgery, definitely somebody could try to have curative dissection.

Q. Do you agree that by December 2016 the PET scan report on Mrs. Reynolds said that her right upper lobe ground glass opacities were stable? Do you agree?

MR. WOOLSEY: What was the date you said? I'm sorry.

DR. MITTLER: 12/12/2016.

A. So, I see there's a CT scan in April of 2016, and it says stable, multifocal bilateral upper lope consolidation, suggesting stable multifocal adenocarcinoma of the lung.

Q. (By Dr. Mittler) Okay. And can you go to the PET scan of 12/12/2016.

A. And it says stable masslike consolidation left upper lobe, comparably is significant decrease in size, and left upper lobe satellite lesion is unchanged, and the SUV is different in that. Then right upper consolidative ground glass areas remain unchanged.

And so, most of the lesions seem stable and one of them has decreased in size. Even in the left upper lobe, between the two lesions there was changes in the hypermetabolic activity.

Q. Was there more or less hypermetabolic activity in the left size?

A. So, no. The left tu- -- left side tumor had two parts to it. There's a bigger lesion and then a satellite lesion. The SUV of the bigger lesion was 6.1, and the smaller lesion was 3.1.

Q. And, in fact, did the right side change in its SUV value?

A. Compared to?

Q. Compared with the previous values that we've looked at.

A. It was stable.

Q. It was stable. So, the right side that you said was tumor hadn't been changing; correct?

A. It had gotten a little smaller.

Q. And that's an area that there was no -- there was absolutely no biopsy evidence of tumor in the right upper lobe; correct?

A. They had done one time biopsy. And they had biopsied the left one which was negative, as well, before.

(Exhibit 8 was marked.)

Q. (By Dr. Mittler) I'm going to hand you what's been marked Exhibit 8, which is a copy of an article from the Journal of Clinical Oncology.

MR. WOOLSEY: Do you have a copy for me?

DR. MITTLER: Not for you, but (handed document to Mr. Woolsey). I'm sorry. If you'll hand it back to me.

MR. WOOLSEY: Yeah. Let me do this. I'm going to take a picture.

Q. (By Dr. Mittler) First of all, are you familiar with the Journal of Clinical Oncology?

A. Yes.

Q. Is that a journal that clinical oncologists treating patients with non-small cell lung cancer rely on for information about how to treat cancers like Mrs. Reynolds had?

A. It's one of the journals.

Q. And this is -- This article is from the Update Committee of the American Society of Clinical Oncology; is that correct? Do you see that?

A. Yeah.

Q. And do you see under the methods -- Well, first of all, the purpose, can you read the purpose of this.

A. To provide evidence-based recommendations to update the American Society of Clinical Oncology guideline on systemic therapy for Stage IV non-small cell lung cancer.

Q. And you said, at the very first visit with Mrs. Reynolds, that she had Stage IV non-small cell lung cancer; correct?

A. Uh-huh.

Q. And can you read the "Methods" section, what it says there at the top under the abstract, please.

A. An Update Committee of the American Society of Clinical Oncology non-small cell lung cancer

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Expert Panel based recommendations on a systematic review of randomized controlled trials from January 2007 to February 2014.

DR. MITTLER: Now can you turn over to the page 3503, please.

MR. WOOLSEY: Are you going to need this back pretty quick?

Q. (By Dr. Mittler) Have you seen this article before?

A. I don't remember.

Q. And do you see up at the top of the -- I'm sorry -- the first page it says the -- the date of publication was October 20, 2015?

A. Uh-huh.

Q. So, this, in fact, would have been relevant? Would you agree this article would have been at least in force so to speak or what oncologists were looking at in December -- November and December of 2015, when you were formulating decisions about how to treat Mrs. Reynolds? Do you agree?

MR. WOOLSEY: Form. Go ahead. You can answer unless I tell you not to.

THE WITNESS: Okay.

A. So, it's one of things we -- we could follow.

Q. (By Dr. Mittler) All right. So, if you look

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at page 3503, do you see Clinical Question A5 on the right-hand column?

A. Uh-huh.

Q. And it says, "What is the most effective first-line therapy for patients with Stage IV NSCLC with ALK gene rearrangement and PS 0 to 1 or possibly PS 2?" Do you see that?

A. Uh-huh.

Q. And do you see the recommendation is "If patients have Stage IV NSCLC and ALK rearrangements, first-line crizotinib is recommended..."? Do you see that?

A. Yeah.

Q. Did I read -- I wrote it -- I read it correctly, right?

A. Yes.

Q. And you see the type in parentheses says: Evidence-based, benefits outweigh harms; evidence quality is high; strength of recommendation is strong. Do you see that?

A. Uh-huh. Yes, I do.

Q. Do you agree with that?

A. It's not for everybody.

Q. Well, do you agree that, in fact, that was the standard of care for starting treatment on

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Mrs. Reynolds in November of 2015, when you first saw her?

A. Mrs. Reynolds received standard of care therapy from me.

Q. Did you keep, anywhere in your records, a running total of the amount of cisplatin that you gave Mrs. Reynolds?

A. No, I did not.

Q. Why not?

A. It's not standard of care.

Q. So, it's not standard of care to document the total amount of milligrams per meter square that a patient has gotten; is that correct?

A. Yes.

Q. And what happens if a patient like Mrs. Reynolds is diagnosed with peripheral neuropathy?

A. We change the treatment.

Q. And you -- Did you discontinue cisplatin on Mrs. Reynolds because of the development of peripheral neuropathy?

A. We discontinued it because she was getting weaker.

Q. Do you know how many doses of cisplatin Mrs. Reynolds got after a diagnosis of peripheral neuropathy?

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A. So, Mrs. Reynolds refused to take any gabapentin, saying that she didn't have peripheral neuropathy, that she was -- so, we met with her every week and asked her questions and documented it.

Q. So, it's your testimony that Mrs. Reynolds refused to give -- I'm sorry -- refused to take a medication for neuropathy; is that correct?

A. No. What I meant was she said it was not that bad and she didn't need it.

Q. Okay. Now you used the term "gabapentin". What is that?

A. It's something, when patients say they have tingling or numbness, we offer. It's also used for patients with hot flashes or pain.

Q. So, if a patient is on cisplatin and has developed peripheral neuropathy, is the standard of care to stop the cisplatin or to put them on gabapentin, or both?

A. Both.

Q. And where in the chart -- Where in your records does it say that Mrs. Reynolds refused treatment for peripheral neuropathy?

A. In many places.

Q. Okay. Can you show me.

A. Sure.

Q. Can you show me the first time --
A. Uh-huh.
Q. -- it appears, please.
MR. WOOLSEY: I looked at some things going back in. I looked over there at a half-full box and didn't realize you were replacing things, and I thought, oh, no, oh, no.
A. So, the first time she complained of some peripheral neuropathy was on 11/18/2016. And on 11/25/2016, we graded it as 0 to 1. It says patient does not want medications at this time.
Q. (By Dr. Mittler) For peripheral neuropathy?
A. Yeah.
Q. Does it mention gabapentin?
A. On 12/2 it says it's improving, but she has fatigue and generalized weakness. She said she didn't want any therapy for that because it was getting better. So, on 12/16 she doesn't complain of neuropathy, at all. It has been taken out. Lower doses, Carbo, Procrit, neutropenia. The dose was reduced further on December 23rd.
Q. Let me -- Can I just stop you for one second.
A. Yes.
Q. Can you go back to 12/9/16 --
A. Uh-huh.

Q. -- your visit.
A. I'm on that visit.
Q. Yeah. Could you go to the review of second -- I'm sorry.
Could you go to the "Review of Systems" on Page 2 of 4 of that visit.
A. "Peripheral neuropathy to bilateral hands."
Q. Yes. What's next?
A. "Weakness to bilateral lower extremities. Had a hard time getting up due to fatigue."
Q. Okay. So, is that some evidence of the weakness associated with her peripheral neuropathy that's documented in your records?
A. Not necessarily because here in the "History of Present Illness" it says complains of neuropathy, is improving, but increased fatigue and generalized weakness to her lower extremities.
Q. And at that time you told the patient and her family that she was incurable; correct?
A. I've told the patient and her family she was incurable even before that.
Q. Now, isn't it true that once a patient develops peripheral neuropathy, it doesn't go away? Correct?
A. That's not true.

Q. And, in fact, in Mrs. Reynolds, her cisplatin-induced neuropathy never went away; correct?
MR. WOOLSEY: Form.
A. I don't think she had peripheral neuropathy from cisplatin.
Q. (By Dr. Mittler) Well, what do you think her peripheral neuropathy was due to?
A. She had generalized weakness.
Q. Well, generalized weakness doesn't cause peripheral neuropathy. It's a -- It's a sign or symptom; isn't it?
A. It's a symptom.
Q. Yes. Peripheral neuropathy is an abnormality of the peripheral nerves of the body; correct?
A. Yes.
Q. And peripheral neuropathy is caused by something; correct?
A. You know, if you have anxiety, it can cause us to have tingling and numbness for hands or feet, too.
Q. So, is it your testimony that Mrs. Reynolds' peripheral neuropathy was caused by anxiety?
A. I'm not saying that it's the only cause. Mrs. Reynolds week after week has told us that her neuropathy is ze- -- you know, getting better and she

didn't want any treatment.
Q. Well, in San Antonio a lot of people have diabetes; correct?
A. I think so.
Q. And diabetes is a common cause of peripheral neuropathy; isn't it?
A. It is a common cause of peripheral neuropathy.
Q. So, also in San Antonio a lot of people have cancer; correct?
A. I don't know about that.
Q. Well, you do know that many cancer chemotherapeutic agents do cause peripheral neuropathy? You know that; correct?
A. There are -- There are a few that cause peripheral neuropathy, yes.
Q. And drugs like carboplatin and cisplatin cause peripheral neuropathy; correct?
A. They can.
Q. And the medical literature doesn't say anxiety caused these cancer patients to have peripheral neuropathy; correct?
A. So, I'm saying that tingling and numbness of the hands and feet could be also sometimes from anxiety.

Q. But in your own records you diagnosed peripheral neuropathy; didn't you?
A. And it says it's improving, it's grade zero, and she didn't want any therapy.
Q. Well, you stopped the cisplatin; correct?
A. Because she was getting weaker.
Q. But, in fact, you gave how many more doses of cisplatin after you initially diagnosed the peripheral neuropathy?
A. Three half doses.
Q. Three half doses?
If you'll look at the log here -- again, if our -- if our records are correct, based on your billing records, you gave cisplatin on -- 40 milligrams on 11/11/16. Can you verify that?
Let me help. Would the billing records help you?
A. It doesn't help because there could be wastage.
Q. Well, do the billing records -- If you've billed for cisplatin, doesn't that indicate that you gave the patient cisplatin?
A. No.
Q. Why not?
A. Because sometimes the vials come in a higher

denomination than the patient receiving the drug.
Q. So, you bill for the part that you don't use; is that correct?
A. Yes. They write it as wastage, but we still have to bill for it.
Q. What do you do with the wastage of that drug?
A. We throw it away.
Q. So, there's a -- if a billing record of 11/11/2016, one of your billing records, says that you billed for 40 milligrams of cisplatin, does -- that doesn't mean that you gave the patient 40 milligrams of cisplatin?
A. It may not. We just have to see the chemo administration log.
Q. Well, that record says that on 12/6/2016 Medicare paid you $6.49 for that cisplatin and apparently another $7.85. Does that -- Does that make sense?
A. I can look at the medication administration and tell you what I see.
Q. All right. Can you look at the medication administration from 11/11/2016, please.
A. Yes.
DR. MITTLER: Can I --
MR. WOOLSEY: Yeah, that's fine.

Q. (By Dr. Mittler) In the interest of time, can I just show you my copy.
A. Sure. Yeah, she got 40 milligrams.
Q. And was there any waste?
A. I don't see that charted.
Q. Well, the waste says zero; doesn't it?
A. Yeah.
Q. So, is that an accurate number?
A. I don't know.
Q. Well --
A. I don't -- Sir, I don't go and administer chemotherapy. I can definitely ask my nurses and let you know.
Q. Well, Dr. Rao, I understand your nurses administer the chemotherapy. Is that correct?
A. Yes.
Q. But isn't the --
A. I just write the orders.
Q. Okay. Isn't the administration of the chemotherapy under your control?
A. Yes, sir, it is.
Q. And it's under your --
A. It's supposed to be.
Q. And it's under your supervision --
A. Yes.

Q. -- correct?
A. Yes.
Q. And can we assume that what is present in this nursing administration record, of the medications given to Mrs. Reynolds on 11/11/2016, is accurate?
A. If it says no waste -- Let me see one thing. Okay? Just give me one second.
So, according to this, 40 milligrams was given.
Q. And there was no waste; is that right?
A. Yes.
Q. Under the waste column it says zero --
A. Yes.
Q. -- correct?
A. (Witness nods head up and down.)
Q. All right. Is there another part of your record where there's a record of an audit of this nursing record or a -- somehow some kind of a documentation of waste that -- that, in other words, is additional information to these -- this section of nursing notes that we're looking at?
A. I don't think so or I'm not aware of it.
Q. Well, how do you audit this nursing record?
A. My billing staff do it.
Q. So, you don't audit it?

A. Not on every patient.
Q. Well, how do you know the nurses gave 40 milligrams of cisplatin?
A. So, I write the orders, and we have three people who verify -- somebody who pulls the drug, make sure that it's the same patient, and then we have a -- you know, a pharmacy personnel who mix it, and then the administrator.
Q. Maybe I misheard you, but I -- but I thought I heard you say that you couldn't tell by looking at these records or this record that you have in front of you, the nursing record, whether or not there was any waste or not from the cisplatin that was given.
A. I just don't know the process that is involved in it. That's all. Like the billing and how it is charted, I don't know that.
Q. Well, who supervises the billing in your practice?
A. We have a supervisor for that.
Q. All right.
A. Actually, two of them.
Q. How do you know the bill that goes in to Medicare and BlueCross BlueShield in this case with Mrs. Reynolds, how do you know those bills are accurate?

A. So, there is a link system that they pull the drug from. So, that would show how much was dispensed, and then the nurses chart it.
Q. So, how does the billing department know how much to bill, say, Medicare for?
A. Oh, they -- The yellow sheet, they write on that.
Q. Okay. What -- What are the yellow sheets?
A. Let me see. You know, we transitioned to this EMR system, and I'm not that savvy with it. So, we had a different one before and this. So, I'm just...
DR. MITTLER: I'm going to resist from making any sidebar about EMR systems which are the cause of doctor burnout these days.
THE WITNESS: I agree with you on that 100 period.
MR. WOOLSEY: We've found some common ground.
DR. MITTLER: We have. We agree.
MR. WOOLSEY: We've found a place with commonality.
DR. MITTLER: We agree.
A. Sir, all I see here is that says 10 milligram, four. And I could definitely find out

and get back to you about how to see how they do that.
Q. (By Dr. Mittler) Do you have a yellow sheet for that date --
A. Yeah.
Q. -- 11/11- --
A. It says --
Q. Can you --
A. That's all it says.
Q. Can you show that to me.
A. Uh-huh, yes.
Q. I'd like to look at it just to...
MR. WOOLSEY: Just hand him the whole stack.
DR. MITTLER: Was that -- Were these also disclosed to us?
MR. WOOLSEY: I believe they were. If they weren't --
THE WITNESS: See here (pointing) it says three. That's cisplatin, 10 milligrams. That's how it's billed.
DR. MITTLER: I see. Okay.
MR. WOOLSEY: If those haven't been produced, that's --
MR. POWELL: They are now because --
MR. WOOLSEY: -- my oversight.

MR. POWELL: -- that's Exhibit 1.
DR. MITTLER: Yeah. We have them now.
MR. WOOLSEY: Yeah. If they hadn't been, that's my over- -- I wasn't trying to hide them from you.
DR. MITTLER: I understand. I just...
Q. (By Dr. Mittler) Okay. So, this is a -- This is a system of where the -- at least at this point in time, is this your -- your nursing staff makes notes of the specific amounts of the various drugs and IV materials and saline solution is given --
A. Yes.
Q. -- correct?
A. Yes.
Q. And then that's translated into this other record, these nursing notes; is that correct?
A. Yes.
Q. And then that's also linked to a billing system; is that correct?
A. Yes.
Q. So, the primary source of what's given at any visit are these yellow sheets of paper; is that correct?
A. Yes. And which is not filled by me. I only would fill the visit. And then whoever, you know,

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administers that, they fill it.
Q. During this period of time that you -- that Mrs. Reynolds was under your care, did you ever have a contract nurse, a nurse who was working under contract, who wasn't a so-called regular employee, who was seeing her?
A. I don't think so.
Q. Susan Reynolds, her daughter --
A. Uh-huh.
Q. -- when she's deposed, I'm going to represent is going to testify that -- that there was a contract nurse, someone who was a little bit older, with short gray hair, who saw her mother for a period of time. Do you know who that might be?
A. She may be thinking it's a nurse practitioner or a nurse?
Q. A nurse practitioner.
A. No contract nurse practitioner.
Q. You had no nur- --
A. (Witness shakes head side to side.)
Q. And did you have any nurse who was older and have short, gray hair, nurse practitioner?
A. I'm the one who's old.
Q. I'm not going to ask you whether your hair is dyed.

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A. Yes, it is. Of course, it is.
Q. You don't have to tell that.
A. It's okay.
DR. MITTLER: I'm going to object to my own question.
MR. WOOLSEY: Sustained.
A. Sir, all I can tell you is Ms. Susan Reynolds and Mrs. Reynolds, they were very nice people. And we spent a lot of time every week talking to them. There were issues, you know, like any other family. Like, I really think everybody was trying to look out for, you know, each other, but, you know, just having cancer is stressful enough. They're older. You know her husband was also older. So, I think there was a lot of -- me, I can tell you it's hard enough taking care of myself. You know?
So, every week we spent a lot of time. We addressed everything to the best of our ability, and we tried to keep one step ahead of it. You know? So, we tried to give the best care we can and be responsive to nutrition, social/family issues, and everything for all our patients.
Q. (By Dr. Mittler) Was there any nurse practitioner who left your practice during this period of time, who was disgruntled, unhappy with the

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practice?
A. I could go back and look. Nurse practitioners -- I can go back and look.
Q. And, again, I'm going to represent that Susan -- Susan Reynolds is going to testify in her deposition that there was this nurse practitioner who worked for you for a relatively short period of time, who saw her mother, who she had good rapport with, who had advised her to get a second opinion about the treatment she was getting. Do you have any knowledge of that?
A. No, sir.
Q. You had no -- There was not one of your nurse practitioners who came to you and said I'm disagreeing with the treatment of Mrs. Reynolds or any other patient?
A. (Witness shakes head side to side.)
Q. Did that ever happen during this period of time?
A. No, sir.
Q. Have you had any other patients who have complained to you about the kinds of treatment they were getting, in other words, they weren't getting the right treatment or they wanted second opinions because they had read on the Internet that they should have

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been getting some other kind of treatment?
MR. WOOLSEY: Form. Go ahead.
A. My -- in my practice -- this is my very first law -- I mean this is the first law --
THE WITNESS: What do you say? Lawsuit, right?
A. So, we have long-term patients. Even after patients pass away, their families come and help us and take -- you know, so the attrition rate is very, very low.
Q. (By Dr. Mittler) So, you have -- You've had not other medical malpractice lawsuits involving questions of your standard of care; is that correct?
A. Yes.
Q. This is the very first?
A. This is my first lawsuit.
Q. Have there been any other inquires or investigations as to your billing practices or the kinds of drugs that you've been giving, by any regulatory entity, say Texas Medical Board or Texas Department of State Health Services, any entity like that?
A. State Health Services, what do they do?
Q. Any Texas -- Well, they run hospitals for example. Have you had any kind of investigation like

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that?
A. What was the first one?
MR. WOOLSEY: Form.
Q. (By Dr. Mittler) The Texas Medical Board.
A. About my billing practices?
Q. Either billing or the kinds of medicines you're giving or the amounts of medicines that you're giving for cancer.
A. No.
Q. Have you ever been subject to any government investigation about your cancer therapy practices?
A. Not about my cancer therapy practices.
Q. What have you been contacted about by the government?
MR. WOOLSEY: Form.
A. So, I've -- on my notes there -- there was a time where I had to, you know, make sure that there were certain things like put the primary diagnosis -- like the format that we have now, that -- on my notes.
Q. (By Dr. Mittler) So, there was an investigation as to the adequacy of your medical records; is that correct?
A. Not the medical records per se. Just about the formating of it.
Q. What -- Did that investigation have to do

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with whether there was enough support to justify your billing?
A. No.
Q. So, what was the investi- -- I'm still not understanding what the investigation was about.
A. So, the investigation was about that it has to have a primary diagnosis and -- What's the other one? About -- So, the way we have it now, that's how they wanted us to do the notes. That was because of certain things that happened with my former partner. It had nothing to do with billing practices or nothing like that.
Q. Who -- Who conducted that investigation?
A. It was an agency for the -- What do you say? I guess the CMS have somebody oversee.
Q. So, "CMS" stands for Center for Medicare & Medicaid Services?
A. Uh-huh.
Q. So, that's a -- That's a branch of Health and Human Services; correct?
A. I don't know. You said Texas Health Services.
Q. No. You -- I'm sorry. You just said that this investigation you were talking about was conducted by some entity associated with CMS; correct?

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A. Right. It's a private -- private person. But I -- I passed it with 100 percent compliance.
Q. Okay. I'm just trying to -- instead of our talking "doctor talk," I'm trying to take this -- you know, these alphabet soup sort of things and explain them to the jury because we have the jury listening.
So, "CMS" stands for Centers for Medicare & Medicaid Services; is that correct?
A. Yes.
Q. And that's a branch of the federal government; correct?
A. Yes.
Q. And that's the branch that oversees, for example, Medicare benefits; correct?
A. Yes.
Q. All right. So, did this investigation have to do with Medicare benefits?
A. No.
Q. Did it --
A. It's just about notes.
Q. Okay. Did it have to do with the -- your progress notes and medical records for Medicare patients?
A. Just -- Just the formatting of my progress notes.

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Q. All right. And why -- What were they critical of in your progress notes?
A. So that it didn't -- so, if you look at my notes from before --
DR. MITTLER: I'll take that. Thank you.
MR. WOOLSEY: Is that part of yours? I just want to make sure we don't lose any of our --
DR. MITTLER: It's mine.
MR. WOOLSEY: I don't want to lose any of Exhibit 1. I think we've muddied the question. You might have to re-ask it. Sorry.
DR. MITTLER: What was it? Can you read the question back, please.
THE REPORTER: "What were they critical of in your progress notes?"
A. That we had to have a primary diagnosis, and they were -- you know, there are certain notes where there are two handwritings. It's because I closely supervise my nurse practitioners. So, they do a note, and I always -- you know, like Mrs. Reynolds, right, I -- if there is a problem, I don't let my nurse practitioners take care of it. I will go in and I will add, you know, to the notes. So, that -- that was another question as to why there was like two signa- --

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two different handwritings on a note.
Q. (By Dr. Mittler) When did this investigation occur?
A. In 2016.
Q. And was it resolved in 2016?
A. Yes.
Q. Were you represented by a lawyer then?
A. No.
Why is it that you-all have to -- I told you I passed it with 100 percent compliance.
MR. WOOLSEY: Hold on. He didn't --
DR. MITTLER: Well, there's no question on --
THE WITNESS: No, but, you know, they're just trying to --
MR. WOOLSEY: Stop.
THE WITNESS: Right.
MR. WOOLSEY: Stop it. Stop, stop, stop.
Q. (By Dr. Mittler) Has the -- You said that you supervise your nurse practitioners. When we look at your progress notes or your records on Mrs. Reynolds, how do we know whether the nurse practitioner alone saw the patient and then later on you came and looked at the progress note or you

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actually yourself were there seeing Mrs. Reynolds at the time?
A. So, every case we discuss so nothing happens there without, you know -- so, I guide and look at everything. Every case is discussed with me. And any difficult patient I would go and -- see, when -- when I have a busy practice -- like Mrs. Reynolds, for example, takes 45 to 50 minutes every visit. You know? I want the patients to feel like they have that kind of support. That's why we have med levels so that they get that kind of time, you know, with the -- with the provider, all their issues are addressed.
And, you know, from -- see, you can see from the 2015 notes to now notes. You know, the documentation, that has been the biggest issue of, you know, if somebody was leaving. This is the depth of a practice. You know, you have to document all of this.
Q. But isn't it true that with the electronic medical record, the EMR, that one of the reasons that the records on Mrs. Reynolds, some of them have exactly the same verbiage, is that you can cut and paste from one visit to the next visit?
A. We don't cut and paste.
Q. But many of the words are exactly the same. And --

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A. So, the past medical surgical social history we update them. You know, if somebody went to the hospital, we'll update it. Some medi- -- every -- So, I have an MA who goes in and gets a few, like, information. And then the nurse practitioner will also sit down and make sure everything is accurate.
And, you know, when you are spending 30, 40 minutes counseling about eating and drinking, and looking at every problem, and addressing it, it you know, sometimes I spend every Sunday charting. I've done that for 12 years. I work six and a half days a week. This is my life.
My point, though, is there's complex issues. You know, there could be low white count, high white count, you know, anemia, magnesium, psychological issues, fatigue, weight loss, low albumin. It's not one. When you take care of cancer patients, there's at least 14 different things we are looking at.
Q. Were there some visits where Mrs. Reynolds was seen in your practice, where you did not see Mrs. Reynolds during the time in which she was in your office?
A. There have been visits where I didn't see Mrs. Reynolds.
Q. So, how do we know the visits where you

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personally saw Mrs. Reynolds and the visits where you didn't see Mrs. Reynolds but reviewed the chart with a nurse practitioner after the visit?
A. Sometimes there will be, you know, my handwriting on the note.
Q. Well, look at -- Can you look at the record, for example -- Do you have that in front of you? Could you look at the record of, say, 5/15/17.
A. 5/15/17 --
Q. Yes.
A. -- or 5/12/17?
Q. I'm sorry. 5/5/17. I'm sorry. 5/5/17. May 5, 2017.
A. This -- So, it looks like Reylin, my nurse practitioner, saw her. And it says discuss with Dr. Rao; currently on gabapentin, 100 milligrams; neuropathy has improved; will be evaluated in early 6/2017; has physical therapy coming to her house; weakness and gait have improved.
Q. Okay. So, this is -- This is a five-page progress note; is that correct?
A. Yes.
Q. All right. And it does say that she was taking gabapentin; correct?
A. It does, uh-huh.

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Q. So, at that point in time she hadn't refused gabapentin; correct?
A. No. She's only taking it once a day. She didn't want to take any more of that.
Q. Okay, all right. Maybe I misheard you. So, I thought you had testified she had refused gabapentin.
A. In the beginning. That was in two-thousand- -- the previous year.
Q. But she --
A. We started off with -- in 11/2016. This is 5/2017.
Q. So, if we go to Page 5 of 5 of this visit --
A. Uh-huh.
Q. -- do you see that it's signed by Reylin Segura --
A. Right.
Q. -- NP?
A. (Witness nods head up and down.)
Q. Is that correct?
A. Yes.
Q. And that's your -- That's one of your nurse practitioners --
A. Yes.
Q. -- correct?
A. (Witness nods head up and down.)

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Q. And then below it you signed it?
A. Right.
Q. So, how do we know how much time you actually saw Mrs. Reynolds or if you saw her at all?
A. All the notes have to be countersigned by me.
Q. Okay. I understand what you're saying, but my question is: From looking at the record, how do we know if you personally saw Mrs. Reynolds while she was there or you merely conferred with your nurse practitioner sometime after Mrs. Reynolds was there and had left the office?
A. Or before. Or before she saw her, too.
Q. Well, you couldn't sign off on the record --
A. Not the re- --
Q. -- until the visit was done; correct?
A. So, the signing off of the notes and the visit doesn't have to be in real time.
Q. Well, it can't be before the visit, can it?
A. No. I'm saying this -- I could -- Sometimes they talk to me before they go see the patient, too.
Q. But you -- But in order for you to sign off on this progress note, you have to review everything in the progress note before signing off on it; correct?
A. I do. We talk about patients, and then they type up the notes, and we sign off on it.

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DR. MITTLER: Let's go ahead and take a break. I know you want to take a break.
THE VIDEOGRAPHER: We're going off the record at 12:41.
(Recess.)
THE VIDEOGRAPHER: We are back on the record at 1:48.
Q. (By Dr. Mittler) Okay, Dr. Rao. We're back on the record and you're still under oath. Do you understand that?
A. Yes, sir.
DR. MITTLER: Okay. Let me hand you what we're going to mark as Exhibit 9.
(Exhibit 9 was marked.)
THE WITNESS: Thank you.
Q. (By Dr. Mittler) And this is a --
MR. WOOLSEY: Can I see it real fast.
DR. MITTLER: Yeah, that's yours.
MR. WOOLSEY: Oh, you've got one for me?
DR. MITTLER: Yes, I do.
MR. WOOLSEY: Okay.
DR. MITTLER: Yeah, that's yours.
MR. WOOLSEY: Thank you.
Q. (By Dr. Mittler) This is a medical article from the -- a journal called Frontiers in Molecular

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Neuroscience, a review article published on 31 May 2017 called "Pathophysiology of Chemotherapy-Induced Peripheral Neuropathy". Do you see that article?
A. Uh-huh.
Q. Could you turn over to page four, please.
A. (Witness complies.)
Q. And do you see in the right-hand column at the bottom it says "Cisplatin"?
A. Yes, I do.
Q. Okay. So, at the bottom of this page and on to the top of the left-hand column of page five, the next page, there's some information that's published about cisplatin with some references. Do you see that?
A. Yes.
Q. All right. Now, the first part of that says, "Cisplatin causes a wide range of side effects including ototoxicity (hearing loss and tinnitus), nephrotoxicity, myelotoxicity and neuropathy..."
Did I read that right? My question is did I read that sentence correctly?
A. Yeah, I'm just trying to find it and follow it.
Q. (Dr. Mittler pointed to the bottom, right-hand corner.)
A. On the first page?

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MR. WOOLSEY: On page four.
THE WITNESS: Oh, I'm on the next page. Thank you.
MR. WOOLSEY: Bottom right corner.
Q. (By Dr. Mittler) Okay. Do you see --
MR. WOOLSEY: She was on page five.
Q. (By Dr. Mittler) Okay. Do you see the -- do you see the --
A. Yes, I do.
Q. All right. So, did I read that first sentence correctly?
A. Yes, you did.
Q. And then it says, "One of the most dose-limiting of these is peripheral neuropathy, which occurs in a dose- and time-dependent manner," and it cites an article from 1985. Do you see that?
A. Yes.
Q. Do you agree with that?
A. I don't have any opinion right now because I have to read it.
Q. All right. And then it says, "The onset of cisplatin-induced neuropathy is variable, with some patients reporting the first appearance of symptoms after the first dose, and others after 12 cycles of therapy," and it cites two references from 1989 and

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1990. Did I read that correctly?
A. You read that correctly.
Q. Do you agree with that -- that statement in general?
A. It could be variable. I agree that it could be variable.
Q. Okay. Next sentence says: Generally, cisplatin-induced neuropathy develops after cumulative doses above 350 milligrams per meters squared, with approximately 92 percent of patients developing neurotoxic symptoms -- characterized by tingling, numbness and mechanical and thermal hyperalgesia -- at cumulative doses of 500 to 600 milligrams per meter square cisplatin, and it gives several references. Did I read that correctly?
A. You read that correctly.
Q. All right. Do you agree with those -- those numbers, that 350 milligrams per meters square and 500 to 600 milligrams per meters square?
A. I have to read the article, so I don't have an opinion right now.
Q. If we look back at that exhibit you have in front of you, about the cumulative dose of cisplatin, which is Exhibit 7, do you know when Mrs. Reynolds reached that -- a dose of 350 milligrams per meters

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square or -- and 500 to 600 milligrams per meters square?
THE WITNESS: Can I have a pen? I can write on this, or not?
MR. POWELL: Go ahead.
DR. MITTLER: Yeah, you can write on it. Is that okay with you?
THE WITNESS: No?
DR. MITTLER: Well, here, let me do this.
THE WITNESS: Just give me a piece of paper.
DR. MITTLER: Let's give another --
MR. WOOLSEY: I can give her a piece of paper.
DR. MITTLER: Here, let me do this.
MR. WOOLSEY: You just need something to do some math on?
THE WITNESS: Yes.
MR. WOOLSEY: Okay.
DR. MITTLER: Just use a piece of paper, and we'll mark it as an exhibit.
(The witness is writing on a yellow piece of paper.)
A. So, it looks like she may have been close to

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500 milligrams per meters square, total.
Q. (By Dr. Mittler) You mean at 12/30/2016?
A. Uh-huh.
Q. Well, she had -- She had gotten 1234 milligrams; correct -- is that correct, by 12/30/16 --
A. So, she had --
Q. -- of cumulative dose?
A. -- received 384 plus 800 plus 50, yeah. So, that's about 600 milligrams per meters square.
Q. Well, if you -- at the very end of her -- if these numbers are correct, and I know you and your counsel are going to check them, but if the number 1234 total milligrams of cisplatin that she had achieved by 12/30/16 is correct, then if you divided 1234 by, what, 1.7 meters --
A. Uh-huh.
Q. -- that comes out to 725.88; doesn't it?
A. If that's the amount, yeah.
MR. WOOLSEY: It's 34. 34, Brant. You put 8.
DR. MITTLER: Oh, sorry. 12- --
MR. WOOLSEY: 1, 2, 3, 4.
DR. MITTLER: Okay.
A. 725.

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Q. (By Dr. Mittler) .88; is that right?
A. (Witness nods head up and down.)
Q. Okay.
A. From your numbers, yeah.
Q. And, in fact, by the time she got to 12/30/2016, her body surface area was smaller because she had lost weight; isn't that true?
A. I can check. She had lost weight from before.
Q. Well, what was her weight on 12/30/16?
A. 114 pounds.
Q. 114 pounds; correct?
A. Something like that.
Q. And she had started at 138 pounds, right?
A. 134.
Q. Or 135 pounds?
A. Uh-huh.
Q. So, what was her body surface area on 12/30/16? Well, let me -- Let me just ask you this question. I'm going to withdraw that question.
Is it fair to say that her body surface -- is it fair to say that her meters -- that her square meters were lower on 12/30/16 than they were when we started --
A. Yes.

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Q. -- your treatments; is that correct?
A. Yes.
Q. Let me say it again.
Is it fair to say that Mrs. Reynolds' square meters body surface area were lower on 12/30/16 than when you first started treating her in November of 2015?
A. Yes.
Q. So, that would mean that the dose of cisplatin per meters square was actually higher than 725, which was the number based on the body surface -- the meters square body surface area than when she had started; correct?
A. I'll have to do the calculation, but it seems logical.
Q. Seems logical, yes. Okay.
So, do you -- Do you agree that the cisplatin caused the neuropathy in Mrs. Reynolds?
A. I don't know if she had neuropathy to the extent that you are talking about.
Q. Okay. If would you go back to the article that's in front of you, Exhibit 9, on page -- now we're on page five, the top of that left-hand column.
It says -- The next sentence says, "Cisplatin-induced CIPN," which I believe is

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cisplatin-induced peripheral neuropathy, "affects mostly the lower and upper limbs and includes mixed sensory and motor effects, including loss of vibration sense and taste, paresthesia, weakness, and tremor..." Did I read that correctly?
A. Yes.
Q. And then it cites, in parentheses, two references from 1992 and 2011. Do you see that? Did I read that correctly?
A. Yes.
Q. So, I believe you had some earlier testimony that it was your opinion that cisplatin caused sensory neuropathy but not motor neuropathy. Did I -- Am I characterizing that correctly?
A. From all the notes that I have seen, I did not think that Mrs. Reynolds had neuropathy.
Q. Well, your notes clearly say that she had peripheral neuropathy, don't they, on Mrs. Reynolds?
A. It says Grade 0 to 1.
Q. But you have -- The term peripheral neuropathy is in your progress notes on Mrs. Reynolds, isn't it, in multiple occasions?
A. So, what I'm trying to explain to you is the weakness -- generalized weakness that she had -- she didn't say, oh, my hands are tingling or they are numb.

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So, we have the home health people, we have all the notes from them about all the physical exam, and we also have physical exam documented. So, I really don't think she had worsening peripheral neuropathy.
Q. Well, did she have peripheral neuropathy?
A. It seems like for a couple of weeks she had said, but it -- but it also says that it was improving, and she doesn't have any complaints from all the notes we just reviewed before lunch break. It -- It says that she was getting better.
Q. If you would look at your last follow-up visit on 6/2/17. Do you have that in front of you, Dr. Rao?
A. 6/2/17?
Q. Yes, ma'am.
A. Uh-huh.
Q. Okay. If you look on the second page, again under "Review of Symptoms" --
A. Uh-huh.
Q. -- under neurologic --
A. Uh-huh.
Q. -- it says -- and I believe it's in -- It's in bold; correct?
A. Uh-huh.
Q. In bold print it says, "Unsteady gait.

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Peripheral neuropathy: to bilateral hands. Tremors," That's all in bold; is that correct?

A. Yes.

Q. And that's on Mrs. Reynolds on 6/2/17; correct?

A. Yes.

Q. And then if you go to the last page, 4 of 4, correct, under your "Impression & Plan" No. 5, do you see that?

A. Uh-huh.

Q. Again, in bold it says "Peripheral Neuropathy".

A. Uh-huh.

Q. So, do you agree that according to your own documentation, that the last time you saw Mrs. Reynolds she had peripheral neuropathy?

A. It doesn't say, you know, what is the degree of it. And I'm trying to corroborate all this with the physical therapy, you know, where they have tested every muscle in her body. So, my thing is, when we have a problem list, we keep that problem list to make sure we don't forget something.

Q. So, is it your testimony that this -- the medical record of 6/2/17, which is a contemporaneous medical record on Mrs. Reynolds' visit --

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A. What's a contemporaneous mean, please. I'm sorry.

Q. Let me start again. So, do you agree that the medical record, these four pages on Mrs. Reynolds, dated 6/2/17, which is a real-time medical record, it was produced real time the time she was there, is not accurate in terms of the diagnosis of peripheral neuropathy?

A. I -- it doesn't say that -- It doesn't quantify anything.

Q. Are you saying today now that -- that what this record really means is she had peripheral neuropathy in the past, but she doesn't have it today?

A. Well, the problem list is not showing, you know, is it debilitating, is it serious. We don't know that.

Q. Well, the problem list is peripheral neuropathy?

A. Yeah.

Q. And she's currently being treated for it. It says, "Currently on Gabapentin 100mg PO BID". Correct?

A. And physical therapy.

Q. And the gabapentin was prescribed for peripheral neuropathy; correct?

A. Right.

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Q. Well, if she didn't have peripheral neuropathy, why are you prescribing gabapentin to her?

A. What I'm trying to tell you, sir, with all due respect, is that -- so, she started experiencing some symptoms in November. Right? Then as we go along, we have charted that it was getting better and she was refusing to take any medications because it wasn't that serious or severe.

And we sent physical therapy to her home. She was doing well on physical therapy. And they actually discharged her in June with -- saying she exceeded all the goals of -- it's very elaborate.

So, we have -- we have here, you know, as a problem list saying she has, you know, history of peripheral neuropathy, but it doesn't say it's worse. It doesn't say, you know, none of that. So, you -- I'm just trying to corroborate the whole thing across the board.

And she went to see Dr. Conde. Dr. Conde doesn't talk about any neurological deficit. She saw Dr. Srinivasan, and on that time there is no complaints of neuropathy. There is no physical exam that shows she has motor sensory deficits.

Q. Did you -- Do you know how she got to Dr. Conde's office? Did she get there in a walker, by

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wheelchair? Do you know? Do you know one way or another?

A. I don't know.

Q. Okay. Could you look at your -- You have your records in front of you. Could you look at your progress note of 5/5/2017, which we've reviewed earlier in this deposition.

A. Uh-huh.

Q. All right?

A. Uh-huh.

Q. Do you have that in front of you?

A. Yes.

Q. Okay. Now, this is a five-page note; correct?

A. Uh-huh.

Q. And do you see on page four Problem No. 11? Do you see that?

A. Uh-huh.

Q. It says "Peripheral neuropathy". Correct?

A. Yes.

Q. And then it says, "Currently on Gabapentin 100 mg po QD," which means every day; correct?

A. Uh-huh.

Q. And then it says, "Neuropathy to bilateral hands has improved..." Correct?

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A. Yep.
Q. And then at the bottom it says, "Ok to increase to 100 mg po BID". That means twice a day; correct?
A. Uh-huh.
Q. So, you increased the dose of the gabapentin; correct?
A. Yes.
Q. So -- And then there's a note, "She has PT coming to her house 3x/week, and her weakness and gait has improved". Correct?
A. Yes.
Q. So, she has peripheral neuropathy. You say she's getting better, but you've increased the dose of the medicine for the neuropathy; correct?
A. Yes.
Q. Why did you do that?
A. Because to start with, she should have taken a higher dose. It took her a long time even to accept that much. So, we told her, if you took a little more, you'll even get better faster because here in your HPI it says she comes today complaining of stable peripheral neuropathy. It doesn't say it's worse.
Q. Okay. Now, if you'd go to page two, do you see the "Review of Systems"?

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A. Yes.
Q. Okay. It says under "Musculoskeletal" -- do you see that?
A. Uh-huh.
Q. In bold it says "unsteady gait".
A. Yeah. She's had unsteady gait because she was, you know, not eating, she wasn't -- she was just generalized weakness.
Q. And then it says, "Uses walker to ambulate." Right.
A. She's been using a walker for a year now.
Q. And then it says, "...is walking better this week". Correct?
A. Uh-huh.
Q. And then the -- but the reason she was using the walker was because she had peripheral neuropathy involving both sensory and motor nerves; correct?
A. No.
Q. And then --
A. She was using a walker even from earlier in 2016.
Q. And the neuropathy, in fact, was due to the cisplatin which you gave her and you continued to give her even in cumulative doses that were in the toxic range, with a 92 percent chance of causing nerve damage; isn't that true?
MR. WOOLSEY: Form.
A. No, it is not.
Q. (By Dr. Mittler) If you go back to the -- well, let's -- have you seen Dr. Conde's records about her assessment of -- Have you looked at Dr. Conde's records from 2019?
A. 2019?
Q. Uh-huh.
A. Well, let's start with 2016 first.
MR. WOOLSEY: Hold --
A. Oh, no. 2017.
MR. WOOLSEY: Hold on.
DR. MITTLER: No, no.
MR. WOOLSEY: I know you want to give him information and you want to share with him, but he -- he gets to conduct the examination. So --
Q. (By Dr. Mittler) I want to just --
MR. WOOLSEY: Just answer what he's asking you.
Q. (By Dr. Mittler) I want to just show you Dr. Conde's impression and plan from February 1, 2019, this record. Can you just -- I have a purple tab there. Can you read what she says about the peripheral neuropathy.

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A. "Debility of recent CVA." So, Mrs. Reynolds took her Xalkori and had a CVA. And "...depression and peripheral neuropathy for which she has mobility issues due to foot drop from chemotherapy-induced neuropathy, prior history of urinary tract infection, hypothyroidism and anxiety."
Q. So, the chemotherapy-induced neuropathy was due to the chemotherapy you gave her; correct?
A. That is her assessment. It is not the truth.
Q. Okay. But --
A. She is -- She is weak also from the CVA that Dr. Conde gave her the Xalkori. Maybe if I had given it to her she would have had a CVA ahead of time and not even lived a year and a half.
Q. And Dr. -- so, when Dr. Conde writes on March 8, 2019, "She also has significant peripheral neuropathy from previous treatment as documented before given at another facility," then you would say that's not your chemotherapy that did it; is that right?
A. So, Dr. Conde was asked to document all these things so you can build a case, because Dr. Conde's note from 2017 does not have any of this.
Q. So, is it your testimony that Dr. Conde is documenting her record in a way to support a lawsuit against you?

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A. Yes.
Q. And what's the basis of that?
A. That's -- That's what I think.
Q. Do you have any other --
A. Because --
Q. Do you have any other basis for that?
A. Because we have so many notes from so many doctors, all through 2017, that has nothing mentioned about neuropathy or foot drop. Certainly in two-thousand- -- you know -- -eighteen, after one year she writes, oh, patient has neuropathy due to the chemotherapy that was given.
Q. Well, you saw that when Dr. Conde saw Mrs. -- Mrs. Reynolds for the very first time, the very first thing she did was to have the Baptist laboratory fax her the results of the ALK determination; correct?
A. I don't know what she did first, but she didn't -- her physical exam or review of systems do not show that she has neuropathy. Physical exam didn't show that she had a foot drop, none of that. So, certainly in 2018, she has all these things documented to corroborate yourselves.
Q. And isn't it also true -- Let's continue this in this article. Isn't it also true that the neuropathy of cisplatin progressively gets worse over

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time?
A. No.
Q. Okay. Let's look at this Exhibit 9 that we have.
A. So, the patient completed --
MR. WOOLSEY: Hold on. He doesn't have a question to you.
Q. (By Dr. Mittler) I'd like you to look at Exhibit 9, please, that column. Okay. So, do you see about the middle of that paragraph that we've been reading, after the -- after the term 2007, there's a parenthesis closed and a period? Do you see that?
A. Yes.
Q. All right. Now I'm going to read the next sentence. "The symptoms of cisplatin-induced neuropathy may persist for several months and can progressively worsen over time, a phenomenon called 'coasting'..." Do you see that?
A. Yeah.
Q. And then it -- And it gives a reference to a 1990 article. And then it says, "With higher cumulative doses and longer times of exposure to cisplatin, the severity of CIPN," which is cisplatin-induced peripheral neuropathy, "increases, as does the likelihood of development of a chronic,

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irreversible neuropathy..." Did I read that correctly?
A. Yes, you did read that correctly.
Q. So, in fact, cisplatin-induced neuropathy was documented in your medical records on Mrs. Reynolds?
A. To be mild and improving.
Q. And, in fact, it got worse after she left your practice; correct?
A. How do I know that?
Q. Well, you have Dr. Conde --
A. After one year.
Q. You have Dr. Conde's documentation that her -- her weakness and her -- her neuropathy became worse; correct?
A. That's one doctor who has documented something against 20 people.
Q. Are you and Dr. Conde colleagues or --
A. I don't know who she is.
Q. Have you ever met her?
A. No.
Q. Have you ever had any professional dealings with her?
A. No.
Q. Is there any reason for her to not like you?
A. I'm a competitor.
Q. In what way?

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A. I'm another doctor in the community.
Q. So, do you think that -- that every oncologist is a competitor with every other oncologist?
A. I am not saying that.
Q. But you understand that when you put diagnoses in the medical record, like peripheral neuropathy, and you send a bill in to an entity, like Medicare or BlueCross and BlueShield, you're representing that that's an accurate diagnosis; correct?
A. So, let me say this. The patient has a history of diverticulosis/diverticulitis. Right? So, we dealt with all that in 2016 or 2015. So, if I carried that as a problem list, it doesn't mean that it got worse or, you know, that she currently has diverticulitis.
So, all we can say is that the physical exam, my review of system all the way through the end shows that she was getting better. And the physical therapy people went home. And you can look. They have tested every muscle group, and she exceeded all the -- all the goals, and she was discharged in 6/2017.
And there was a whole year before she went to see Dr. Conde. And so then Dr. Conde puts all these buzzwords to help with the litigation and gives

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her Xalkori. She has a CVA and dies within three months.

DR. MITTLER: Object as nonresponsive.

Q. (By Dr. Mittler) In June -- early June of 2017, Mrs. Reynolds was doing so badly and she was so -- so down that, in fact, she entered hospice with an understanding that she had less than six months to live; isn't that true?

A. Her son, her daughter, both of them wanted her to go on hospice, and that's the God's honest truth.

Q. Well, patients just can't go on hospice on their own; isn't that true?

A. Her daughter was trying to push hospice for over a year.

Q. But a doctor has to certify a Medicare patient --

A. I did not certify her.

Q. But some doctor has to do it; correct?

A. That is not -- that -- I mean you can't pin that on me. I just did what the family asked me to do.

Q. Okay. Doctor, I understand. I've heard your testimony that you didn't do the certification. But I'm just saying, if one of the doctors caring for her certified her for hospice, then they had to represent

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to Medicare, and that's a serious representation --

A. You may want to talk to them, sir.

Q. -- that she had six months or less to live; correct?

A. You may want to talk to them, sir.

Q. And you don't put -- nobody -- if any -- does Dr. -- In your knowledge, does Dr. Srinivasan or any of the doctors caring for her, do they put people on hospice if they're doing great?

A. So, if the family has gotten so tired of carrying for their loved one and they feel that she is weak and they want her to go on hospice, I just help them with that.

Q. Do you understand that prior to your treating Mrs. Reynolds, that she was living in her own home and able to care for herself and her husband? Do you understand that?

A. So -- Yeah. I don't know how she was living. I don't know all that. I don't know how she was.

Q. Well, she -- One thing you could do is to look at her deposition testimony; isn't that correct?

A. About what, sir?

Q. About how she was doing. Would that be a good source of information about how she was doing during the time before and during and after you treated

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her?

A. All I can tell you is I've seen all the records from the hospital when she went into Southwest General. And so, there are other physicians who have documented how she was.

Q. Was Mrs. Reynolds -- was she a truthful person when you dealt with her?

A. I don't know. I don't know, after all these things that have happened, who is truthful and who is not.

Q. So, do you believe that she was not being truthful when she told you and your nurse practitioners about her symptoms during the time you cared for her?

A. So, I -- We listened to her every week, and we took care of everything that she told us.

Q. Well, do you think that Mrs. Reynolds, during the period of time from November of 2015 to early June of 2017, do you think she was not giving you truthful answers because she was plotting a lawsuit against you?

A. So, from our notes it shows that Mrs. Reynolds' neuropathy she said was improving. That's all I can tell you, and even the last note says that.

Q. Do you have anything in your notes, in any of your progress notes or your nurses' progress notes, is

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there anything that you recorded or documented that Mrs. Reynolds was not being truthful you -- with you when she recounted her history to you?

A. I'm not talk -- I mean I am just telling you what we have written down and what the physical -- the --

THE WITNESS: Who was the physical therapy company?

A. Premier Health, what they have written down. I'm just talking about that. I didn't say she wasn't truthful. So. She has been very truthful. She told us her neuropathy was getting better.

Q. (By Dr. Mittler) Have you --

A. So, why do you think she wasn't truthful?

MR. WOOLSEY: Take a breath. Listen to the question he asked you.

DR. MITTLER: Dr. Rao --

MR. WOOLSEY: Y'all will have a better conversation.

DR. MITTLER: Yeah. Again, I'm not trying to be combative here, but the way the deposition works, I get to ask the questions and you answer the questions. Okay? And then your attorney objects when appropriate.

MR. WOOLSEY: Brant is giving me a

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running objection to all of these questions. I'll evaluate them later.

Q. (By Dr. Mittler) All right. So -- But my question is this, and this is a very serious question. Because Mrs. Reynolds filed a lawsuit against you, do you -- did that cause you to then go back over her -- her progress notes and records and question whether she was being truthful with you at the time you saw her?

A. I have not had the time to do all that.

Q. So, the answer is no, you didn't -- you didn't go back and evaluate in that regard?

A. You are -- We are just looking at all this right now, isn't it? That's what I've been doing. You -- We started raising when her neuropathy symptoms even started, so we had just been going over that.

THE WITNESS: I don't understand the question.

MR. WOOLSEY: He just wants to know if you have retrospectively looked at the chart and thought that she was being dishonest with her statements to you. It's real -- he's not --

THE WITNESS: I'm not --

MR. WOOLSEY: He's not trying to trick you in his question. It's just a simple -- He just wants to know your thought process.

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DR. MITTLER: Thank you for being more articulate in that question.

Q. (By Dr. Mittler) Can you answer that question?

MR. WOOLSEY: So, I'll ask it for you.

DR. MITTLER: Yes.

MR. WOOLSEY: He just wants to know if you have looked at your progress notes after the lawsuit got filed and thought that what you were told and documented was untruthful in retrospect.

THE WITNESS: There have been a lot of things that are untruthful in the lawsuit, which is, you know, the family.

MR. WOOLSEY: Hold --

THE WITNESS: No.

MR. WOOLSEY: Hold on.

THE WITNESS: I mean I went back and I looked about that.

DR. MITTLER: Let's --

MR. WOOLSEY: Can we take a break? Can we take a break.

DR. MITTLER: Can you --

MR. WOOLSEY: Will you object nonresponsive, and then --

DR. MITTLER: I'll object nonresponsive,

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and let's --

MR. POWELL: To your question.

DR. MITTLER: -- take a break.

MR. WOOLSEY: Let's take a minute.

DR. MITTLER: I'll object to your question.

THE VIDEOGRAPHER: Going off the record at 2:24.

(Recess.)

THE VIDEOGRAPHER: We are back on the record at 2:32.

Q. (By Dr. Mittler) Okay, Dr. Rao. We're back on the record, and you're still under oath. Do you understand that?

A. Yes.

Q. Okay. Just as a matter of bookkeeping, you wrote down some calculations or the beginning of calculations on the milligrams -- total milligrams of cisplatin per meters squared on Mrs. Reynolds. And we're marking that, whatever you wrote down in red ink in your hand, as Exhibit 10. Do you understand that?

A. Yes.

(Exhibit 10 was marked.)

Q. (By Dr. Mittler) And do you understand that this is an exhibit that your attorney can object to and

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it's not going to appear at trial, you know, until and after he gets to object? And so -- Do you understand that?

A. Please, can you explain again.

Q. Well, you understand that your attorney gets to object to this exhibit marked No. 10, and any other exhibit, if we try to introduce this at trial? Do you understand that?

THE WITNESS: What is that about, Bill?

MR. WOOLSEY: He's just -- He's just telling you that -- that -- He knows that you're concerned that those are incomplete calculations, so he's just telling you that before that would ever go to a jury, I'm going to have a chance to complain about it and we'll have a chance to explain it to the jury and even potentially keep it out of the jury's hands at trial. He's just --

THE WITNESS: Will you remember to do that?

MR. WOOLSEY: I have a mind like a steel trap.

THE WITNESS: Thank you.

Q. (By Dr. Mittler) All right. Do you understand that?

A. Yes.

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Q. Okay, good. Because I want -- I know that before we came on the record you were concerned that these calculations were incomplete, and I wanted to assure you that we were taking that into --

A. I appreciate that.

Q. You know, we're concerned about your concern. So, you understand that?

A. I appreciate that.

Q. Okay.

A. Thank you.

Q. Now let's move on. I want to ask you again -- To go back just to some housekeeping, I want to go back to the issue of the investigation that you said was conducted by CMS, or somebody on behalf of CMS, about your recordkeeping.

A. Yes.

Q. Correct?

A. (Witness nods head up and down.)

Q. All right. Is that investigation complete?

A. Yes.

Q. Now, you mentioned a partner who was involved in that.

A. No. There was a -- There was some issues with a partner before that.

Q. Okay. Was there some issues with a partner

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who was a doctor?

A. She was a radiation oncologist, yes.

Q. Okay. And was that doc- -- Was there an issue about her medical recordkeeping?

A. No.

Q. It was a different issue; is that correct?

A. Yes.

Q. So, was that issue with the other -- with the former partner, the radiation oncologist, did that also involve CMS?

A. It involved a lot of agencies.

Q. A lot of agencies?

A. (Witness nods head up and down.)

Q. Okay. What was -- What was the name of that partner?

A. Dr. Dahiya.

Q. Dr. Dahiya?

A. Uh-huh.

Q. Okay. And where does she practice now?

A. I don't know.

DR. MITTLER: All right. Let me -- let's mark this as --

(Exhibit No. 11 was marked.)

Q. (By Dr. Mittler) I'm going to hand you what's been marked Exhibit 11, which was a copy of an

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article from that San Antonio Express-News, dated November 13, 2014, by Patrick Danner. Do you see that?

A. Yes.

Q. Do you recall this article when it appeared?

A. Yes.

Q. Okay. This is an article about a -- It says, "A new lawsuit alleges Radiation Oncology (ROSA) officials are causing the 'intentional destruction of the medical practice' by, in part, failing to pay for cancer medications, supplies and equipment for ongoing patient treatment in two of its three divisions." Is that correct?

A. The lawsuit --

Q. Yes.

A. -- you're reading -- What you were reading is correct.

Q. I was reading the second paragraph there.

A. Yes. What you were reading is what was in the article.

Q. Okay. And it said that the lawsuit involved Radiation Oncology of San Antonio; correct?

A. Yes.

Q. And was that a company you owned at that time?

A. No. I was --

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Q. What was your relationship to that company?

A. I was just working there.

Q. Well, if you read down it says -- first of all, it says, "Jason Davis, ROSA's lawyer, called the allegations frivolous." Do you see that?

A. Uh-huh.

Q. And then it says that -- There's a quote by Mr. Davis, and then it says Davis represents ROSA and its co-president, Dr. Jayasree Rao, in a lawsuit against Dahiya's husband, Dr. Rajiv Dahiya, who was removed as the practice's president and is part owner in September -- and a part owner in September. Did I read that correctly?

A. Yes.

Q. So, were you co-president of Radiation Oncology of San Antonio?

A. After all that happened.

Q. So -- well, at the time of the -- Were you involved in this lawsuit, at all?

A. So, I was just nobody. And we found out --

THE WITNESS: Am I supposed to answer this?

MR. WOOLSEY: You can answer.

THE WITNESS: Okay.

A. So, in 2014, earlier in the year, we found

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out that our chemotherapy drugs were not being paid. So, I was supposed to be a partner, but they weren't showing me any records, any bank statements, nothing. So, I had to find somebody who will help me get to the bottom of it. So, we found out that Dr. Dahiya had swindled the company of over $20 million.

Q. (By Dr. Mittler) When you say our chemotherapy was not being paid, who is "our"?

A. The three medical oncologists.

Q. And who were you working for at the time?

A. ROSA.

Q. So, you -- Were you an employee of ROSA?

A. Yeah. I was a nobody. We didn't have a contract, nothing.

Q. Well, if you -- Were you working at ROSA?

A. Yes.

Q. What was your position there?

A. I was just an on- -- oncologist.

Q. So, were you a staff member?

A. It's just difficult to explain. It was just a very nebulous relationship. I didn't have a contract, nothing. I was working. We all went to school together, so I just start working with them.

Q. You went to school in India?

A. No. Here at UT Health Science Center.

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Q. So, who -- Who was together at UT Health Science Center?

A. Rajiv Dahiya and his wife.

Q. The three of you?

A. (Witness nods head up and down.)

Q. Anybody else?

A. There are two other medical oncologists, and there were all these other urologists they brought in.

Q. Okay. There was also -- Wasn't there also a urology company that you were a part of?

A. I was not a part of it.

Q. Did you ever own it?

A. No.

Q. You had no ownership interest?

A. (Witness shakes head side to side.)

Q. I'm going to ask about that.

So, what I'm trying to understand is you were working as a doctor in Radiation Oncology?

A. That was just the name of the company.

Q. So, you did not have your own company then?

A. No.

Q. When did you form your own company, Oncology San Antonio?

A. That is not my company, either.

Q. What is your company?

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A. Jayasree Rao, MDPA.

Q. What is Oncology San Antonio?

A. It's just a -- It's just a network where we have a professional association so we can have a discounted drug price.

Q. And who -- who are the -- this entity that you -- What's the name of the entity? I'm sorry.

A. ROSA?

Q. No. The entity that --

MR. WOOLSEY: Oncology San Antonio.

Q. (By Dr. Mittler) Oncology San Antonio, what's the --

A. It is just a -- It's just a name. There's no assets. There is nothing through that company. No employees.

Q. Oncology San Antonio has no employees?

A. No employees, no assets, nothing.

Q. Who writes your check now? Where do you --

A. I write it myself from my MDPA.

Q. So, you get a check from your MDPA?

A. I don't get check. I get direct deposit.

Q. Did you disclose your MDPA in part of your disclosures to us in this lawsuit?

MR. WOOLSEY: I don't know the answer to that.

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Q. (By Dr. Mittler) Did you disclose the existence --

A. I don't --

Q. -- of your MDPA as your employer?

A. Why is that an employer? I just work. That is my company.

Q. Well, you get a check from your -- from MDPA, don't you? Don't you get a salary check?

A. It's my earnings.

Q. Well, do you file a tax -- Does the MDPA file a tax return?

A. Yeah.

Q. All right. Do you file a tax return?

A. Yes. When I make money I file a tax return.

Q. And you get a salary check that says your name MDPA; is that right?

A. (Witness nods head up and down.)

Q. And the patients -- does Medicare -- when you bill Medicare -- we've looked at your billing statements. When you bill Medicare, is your MDPA billing Medicare, or is Oncology San Antonio billing Medicare?

A. The Oncology San Antonio because it was -- it is to get drug discounts.

Q. I'm going to ask you about that in a minute.

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So, Medicare pays Oncology San Antonio; correct?
A. It's a flow -- what do you say -- pass-through entity.
Q. It's a pass-through entity?
A. (Witness nods head up and down.)
Q. And so then the money comes where, to your PA?
A. Sometimes.
Q. Well, what about -- You have other doctors who practice with you, don't you?
A. No.
Q. Well, what about your website? There's other doctors listed on your website. What's their relationship to you?
A. They work there. They all have their own companies.
DR. MITTLER: Okay. Mark this. I'm going to mark Exhibit No. 12.
(Exhibit 12 was marked.)
Q. (By Dr. Mittler) Dr. Rao, this is something I printed from your -- the website of Oncology San Antonio yesterday.
A. Okay.
Q. All right. Does this look familiar to you?

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A. This doctor is no longer in practice.
Q. Well -- well, first of all, I mean is this your -- is this a website of Oncology San Antonio?
A. I don't know.
Q. Well, I mean they're -- what I'm asking you, is there such a thing as Oncology San Antonio website? Is that something that exists?
A. Yes, it looks like it.
Q. Okay. And if you look at page two of this, is that you?
A. Yes.
Q. Okay. And it's a very glamorous picture.
A. But that was before the lawsuit was filed.
MR. WOOLSEY: Low-hanging fruit.
Q. (By Dr. Mittler) All right. But that is -- That is you; correct?
A. Yes.
Q. Now, the next doctor is listed as Dr. Zulfi Jaffar. Am I pronouncing that correctly?
A. Yes.
Q. And is he -- It says he is a board-certified medical oncologist and hematologist; is that correct?
A. I don't know.
Q. Does he practice with you?
A. No.

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Q. Is he part of Oncology San Antonio?
A. He retired.
Q. When did he retire?
A. Before the lawsuit was filed.
Q. Well, when?
A. I'm just teasing?
Q. When did --
A. No. He -- He retired in November 2018.
Q. Okay. How old was he? Do you know how old he was, more or less?
A. (Witness shakes head side to side.)
Q. He looks very young. Did he retire from practice or just left this practice?
A. He retired from practice.
Q. Doesn't practice anymore anytime?
A. (Witness shakes head side to side.)
Q. Did he have to retire, do you know?
A. I don't know anything about it.
Q. Illness?
A. (Witness shakes head side to side.)
Q. Was he fired?
A. No.
Q. Is someone -- How is Oncology San Antonio run? Is there like a board? Is there a president, a vice president, a board of directors?

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A. We all just do our own work. We just have billing. Our -- It's a pass-through entity.
Q. Who super- --
A. That's it.
Q. Who supervises quality?
A. We all supervise quality for our own practices.
Q. And who supervises the billing of Oncology San Antonio?
A. I have my own billing team.
Q. Well, Oncology San Antonio bills Medicare and BlueCross BlueShield, for example; correct?
A. (Witness nods head up and down.)
Q. And those were the two insurance entities involved in Mrs. Reynolds' care; correct?
A. I don't know. I know she has Medicare.
Q. Well, I'm going to represent to you that the other insurance entity was BlueCross BlueShield. All right.
So, let's talk about Medicare. Oncology San Antonio bills Medicare; correct?
A. So, we have an NPI number. Is it an NPI number? Something to bill under.
Q. Yes.
A. Yes.

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Q. Okay. I understand what you're saying. All right.

But who does the physical billing? Is it each office?

A. Yeah.

Q. So, your of- --

A. My practice has its own biller.

Q. So, your practice bills Medicare using the name Oncology San Antonio; is that correct?

A. Yes.

Q. And that's to get -- because you can get a drug discount?

A. Yes.

Q. And why could Oncolo- -- Why couldn't you get a drug discount just as Dr. Rao MDPA?

A. There's some collective benefit.

Q. What does it mean to get a drug discount? Can you explain that.

A. So, if you by 100 vials of let's say cisplatin, right, we'll get instead of $6.00, maybe $6.50.

Q. And what causes -- What gets you the discount?

A. The volume.

Q. Oh. So, in other words, you're saying if

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you -- if you take three or four oncologists and put their needs -- their drug needs together, you can reach the volume level to get a discount; is that right?

A. Yes.

Q. And is that -- Does that also cause Medicare to pay you more money?

A. No.

Q. It doesn't matter?

A. (Witness shakes head side to side.)

Q. How do --

A. Medicare is the bottom of the barrel. It pays 80 cents on the dollar.

Q. So, Medicare you say pays the least of anybody?

A. That's my understanding. I'm sure Medicaid is worse.

Q. So, you bill under the name Oncology San Antonio, but, in fact, it's each doctor's office doing the billing; is that right?

A. (Witness nods head up and down.)

Q. So, you're responsible for your own billing; is that correct?

A. (Witness nods head up and down.)

Q. Now, the next doctor listed is Dr. -- is it Syed Raza?

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A. Yeah.

Q. And does he practice with you?

A. He does not practice with me. He has his on practice in the south side of the town.

Q. All right. So, you say you have two offices, right?

A. (Witness nods head up and down.)

Q. Is there any other doctor with you at the office?

A. (Witness shakes head side to side.)

Q. You're the only person.

A. (Witness nods head up and down.)

Q. Do you-all share call together?

A. (Witness shakes head side to side.)

MR. WOOLSEY: You've got to give a verbal answer.

DR. MITTLER: Yeah.

THE WITNESS: Oh, I'm so sorry.

Q. (By Dr. Mittler) Do you-all -- how many doctor -- hematologists/oncologists share emergency call with you?

A. Nobody.

Q. You take your own call?

A. I don't have anybody in the hospital.

Q. Well, but patients -- patients like

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Mrs. Reynolds can have complications or adverse reactions to --

A. I see my own patients.

Q. -- drugs; correct? Is that correct?

A. If they have some -- something, we try to take care of it as outpatient.

Q. So, you're on call 24 hours a day, seven days a week; is that right?

A. And all my patients have my cell number, yes.

Q. So, do you ever take a vacation?

A. I have not in five years.

Q. And before that -- Well, how long have you been part of Oncology San Antonio?

A. Eleven years.

Q. It's eleven years?

A. Not Oncology San Antonio. It was Radiation Oncology of San Antonio.

Q. When was Oncology San Antonio formed?

A. 2016.

Q. How many offices does it have?

A. None.

Q. The website -- Okay.

A. But it is not Oncology San Antonio's offices. They are my offices.

Q. Well, do you have your own website?

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A. I've been very lazy. I haven't done it.
Q. Does Oncology San Antonio purchase liability insurance?
A. No.
Q. You purchase your own liability insurance?
A. I believe so.
Q. As I recall, when I looked at the website yesterday, there were four office locations listed for Oncology San Antonio. Is that accurate?
A. So, I have an office in Stone Oak and downtown. Dr. Raza has an office in Mission Trails. And Dr. Jaffar sold his practice to the other doctor in there, and he says all his patients in Live Oak.
Q. So, there are four locations?
A. Yeah. But we --
Q. Two --
A. But we --
Q. Two belong to you; is that correct?
A. They are mine, yes.
Q. And your offices, are they owned? Are they buildings you own, or do you lease or rent?
A. Lease and rent.
Q. And so, you -- do you lease them under your name, under your MDPA name or --
A. Uh-huh.

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Q. -- under Oncology San Antonio?
A. MDPA.
Q. So, you personally lease those -- that office space?
A. (Witness nods head up and down.)
Q. Is that correct?
A. Yes.
Q. What ever happened to Dr. Dahiya, who you said stole millions from the -- what, from the practice?
A. (Witness nods head up and down.)
Q. What happened to him?
A. I don't know.
Q. Was he prosecuted by anybody?
A. No.
Q. Did any --
A. He just filed --
Q. -- government entity --
A. He filed --
Q. Did any government --
A. -- for bankruptcy.
Q. Okay. Did any government entity sue him?
A. I don't know.
Q. Did -- Did you recover money from him?
A. No.

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Q. Do you know if the Department of Justice investigated him, Dr. Dahiya?
A. We went to the FBI. We went everywhere.
Q. Do you know if he was investigated?
A. I don't know.
Q. Did Medicare investigate him?
A. I don't know.
Q. Was your problem -- Was your problem with the medical record documentation, which you've told us about earlier, was that related to the problem of Dr. -- that Dr. Dahiya?
A. So, Dr. Dahiya, the only thing he can do to make me miserable is make all these allegations and have me go through audits. That's it.
Q. Okay. Well --
A. He can't do nothing else.
Q. Who did he make the allegations to?
A. I don't know.
Q. But you were audited by CMS; is that right?
A. No. By another -- It was just an internal reporting thing I had to do.
Q. Are you under investigation now by any entity of the federal government?
A. No. What am I being investigated for?
Q. I'm just asking the question.

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MR. WOOLSEY: Just an inquiry.
Q. (By Dr. Mittler) What did you go to the FBI and tell them about Dr. Dahiya?
MR. WOOLSEY: Hold on, hold on. I don't think that a report to the FBI is something that she can disclose, so I'm going to instruct her not to answer that.
DR. MITTLER: Okay.
MR. WOOLSEY: I think that that sort of thing is subject to privilege.
DR. MITTLER: I don't know, but we won't --
MR. WOOLSEY: It's also fairly far afield from what we're here today about.
THE WITNESS: But if you can recover money from Dr. Dahiya, that would be great. You can have it all.
Q. (By Dr. Mittler) The answer -- the question is -- The lawsuit involving ROSA and Dr. Dahiya, what happened to that lawsuit?
A. So, Dr. Dahiya just filed that lawsuit to deflect all the attention on him. That's it.
Q. Was it settled?
A. He went and filed for bankruptcy, and that's it. Who had the money to run after all these things?

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Q. Was the lawsuit ever -- Is it finished? Is it still pending? What happened to it?
A. No. I bought all the lawsuits back.
Q. You bought the lawsuits back?
A. That's something -- You have to ask Jason Davis about it. I don't -- I don't know about all these legal things. All I know is I was screwed.
Q. Is it your testimony that that lawsuit is completed, it's no longer ongoing?
A. Yes.
Q. Is that correct?
A. That is correct.
DR. MITTLER: Let's mark --
(Exhibit 13 was marked.)
MR. WOOLSEY: What are we up to on numbers now? 13?
THE REPORTER: 13.
DR. MITTLER: 13.
Q. (By Dr. Mittler) I'm going to -- before we deal with this next exhibit, the Express-News article said the Dahiyas were "suing Scott Rickenbach, ROSA's former CFO and their financial manager." Is that an accurate description of Mr. Rickenbach?
A. They were all thieves and lowlifes.
Q. Is Mr. Rickenbach still working in

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San Antonio?
A. I do not have any contact with him. I hope they all are having a party somewhere in hell together.
Q. All right. Let me -- let's mark -- I've marked Exhibit 13, which is another something I took off the Oncology San Antonio website yesterday. Could you take a look at that.
Did you have any control of what was posted on this website?
A. I don't.
Q. Who put this up there?
A. I don't know.
Q. Was it one of the other doctors?
A. I don't know. I don't know. This is the first time I'm looking at these things.
Q. Okay. Well, I want you to look back at -- these are -- This is what's been posted on lung cancer on this website. Do you see that? On the first page, do you see down at the bottom it says "Personalized therapy" at the bottom?
A. Yep.
Q. It says, "Personalized therapy: Studies of specific features of lung tumors that can determine whether a certain type of chemotherapy or targeted therapy may be effective." Did I read that correctly?

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A. Where is that?
Q. On the -- Dr. Rao, on the first page, down at the bottom. It says "Personalized therapy".
A. Oh, yes.
Q. Okay. Is that referring to the genetic markers, like EGFR and ALK?
A. Or PD-L1 or ROS or BRAF.
Q. And if you go over to the next-to-the-last page, do you see at the top it says "Targeted drug therapy"?
A. Yep.
Q. It says, "These newer cancer treatments target specific abnormalities in cancer cells and work by disrupting growth of new blood vessels that feed the tumor or blocking the chemical signals that make the tumor grow."
A. Yes.
Q. Did I read that correctly?
A. You read that correctly.
Q. And that -- And some of those chemical signals, are those ALK and EGFR?
A. They could be.
THE WITNESS: Where is the NCCN guideline?
DR. MITTLER: Mark this.

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(Exhibit 14 was marked.)
MR. WOOLSEY: Thank you.
DR. MITTLER: Are we at Exhibit 14?
THE REPORTER: Yes.
THE WITNESS: My forehead.
Q. (By Dr. Mittler) Well, Exhibit 14 is --
MR. WOOLSEY: The rest of you is on the second page.
Q. (By Dr. Mittler) -- something else --
THE WITNESS: Oh, dear.
Q. (By Dr. Mittler) -- I took off the website, the San Antonio Oncology website yesterday, and this is what's listed under your name. Have you seen this?
A. I'm seeing it now.
Q. All right. And if you go over to the third page, do you see that under expertise, your expertise, it says -- bullet four is "Anti-EFGR Therapy". Correct?
A. (Witness nods head up and down.)
Q. That should be EGFR; correct?
A. Yep.
Q. And -- and then the next-to-the-bottom -- The two bottom targets says "Targeted Immunotherapy" and then the last one is "Targeted Molecular Therapy" bullet. Is that correct?

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A. Yes.
Q. And targeted molecular therapy would refer to something like the ALK genetic marker; correct?
A. In the appropriate patient, yes.
Q. And then under associations at the bottom, it says "American Society of Medical Oncology". Do you see that?
A. Uh-huh.
Q. Is that a -- is that a -- Well, what kind of an organization is the American Society of Medical Oncology?
A. I think it's ASCO.
Q. I couldn't find that organization. When I looked, I found the American Society of Clinical Oncology.
A. Clinical Oncology.
Q. So, is that what it is?
A. (Witness nods head up and down.)
Q. So, the American Society -- And you're a member of the American Society of Clinical Oncology?
A. I was. I am no longer a member.
Q. Because earlier we looked at some guidelines on treating lung cancer, from the American Society of Clinical Oncology. Do you recall that?
A. That was Journal of Clinical Oncology.

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Q. But it was from the Society, correct?
A. I don't know. I thought it was Journal of Clinical Oncology.
Q. How long since -- When were you last a member of the American Society of Clinical Oncology?
A. I don't recall.
DR. MITTLER: Well, let's put this last exhibit --
MR. WOOLSEY: Thank you.
(Exhibit 15 was marked.)
Q. (By Dr. Mittler) Exhibit 15 in front of you, this is, again, part of the website of Oncology San Antonio that was -- that I'd printed out yesterday. You can see at the top 12/17/2019.
And this is under the section called "WHAT TO EXPECT". And later it says, "If You or a Loved One is Facing Cancer, You're Searching for Information." Did I read that correctly on the first page?
A. Yes.
Q. All right. Do you see under "Multidisciplinary Collaboration"?
A. (Witness nods head up and down.)
Q. Do you see that?
A. Yes.

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Q. It says, "After confirming your diagnosis, your oncologist will put together your team of treatment specialists -- usually a surgeon, medical oncologist, and radiation oncologist. An integrative oncologist is also available to help you with treatment and quality of life issues. Together, your team develops a treatment plan tailored exactly to your disease, lifestyle and treatment goals." Did I read that correctly?
A. Yes.
Q. In fact, does Oncology San Antonio have a team of treatment specialists?
A. We did.
Q. Do you have it now?
A. We work with others, yeah.
Q. Well, who is your team of treatment specialists?
A. We work with START Center radiation oncologists sometimes.
Q. The START Center?
A. No. The radiation oncologists. We have a professional association.
Q. Okay. Who are those radiation oncologists?
A. His name is Dr. Keith Eyre.
Q. How do you --

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A. He's in Stone Oak.
Q. How do you spell that?
A. E-y-r-e.
Q. Okay. And do you have a surgeon who's part of Oncology San Antonio?
A. Sir, it doesn't say that. It just says you will -- we'll put together a team of treatment specialists. So, we work with surgeons. There are breast surgeons. There are neurosurgeons. There are gastrointestinal surgeons. There are all kinds of surgeons in the community we work with.
Q. So -- so, when you -- When this website talks about the team of treatment specialists, this is a team of specialists that you, Dr. Rao, would put together; correct?
A. Yeah.
Q. It's not a team of specialists that exists at Oncology San Antonio; right?
A. I don't think it says that.
Q. Well, would you agree that this might give the impression, of somebody looking at Oncology San Antonio, that, in fact, there was a team of specialists there?
A. I don't know.
Q. Do you think this is truthful advertising?

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A. Sir, I didn't put this together.
Q. Well, who put it together?
A. I don't know.
Q. But your name is there, and your picture is there; correct?
A. And I am sorry. I will go and remove everything today.
(Exhibit 16 was marked.)
Q. (By Dr. Mittler) I've handed you what's been marked Exhibit 16, which is a copy of an article from The Texas Tribune, by Becca Aaronson, A-a-r-o-n-s-o-n, and Alexa Ura, U-r-a, dated April 14, 2014. Are you familiar with this article?
A. No.
Q. The article says "Medicare Data Shines Light on Billions Paid to Texas Doctors". Do you -- Do you recall this issue coming up in 2014?
A. I don't recall.
Q. All right. If you turn to page -- If you turn to the second page of the article, do you see that?
A. (Witness turned to the second page.)
Q. This article is a list of the -- This table that you're looking at, at the top, is a list of the 20 doctors in Texas who were paid the most by Medicare.

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Do you recall that issue that came up?
A. Vaguely.
Q. Vaguely. And I believe you're listed as No. 15 on that list, having been paid $3.33 million in 2012 by Medicare.
A. Okay.
Q. Is that accurate, that number?
A. I don't know.
Q. Do you recall newspaper articles about that?
A. Yes. Did you read that?
Q. My question is do you recall that there were newspaper articles about that, The Texas Tribune and others; correct?
A. I don't know about Texas Tribune.
Q. All right. What about the San Antonio Express-News?
A. Yes, I did give them an interview.
(Exhibit 17 was marked.)
Q. (By Dr. Mittler) I marked as Exhibit 17 a San Antonio Express-News article, dated April 10, 2014, that's -- the headline is "Two S.A. doctors are on list of top Medicare payments," and then it says "Correction Appended". Do you see that?
A. Yes.
Q. Okay. Do you recall this article?

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A. Yes.
Q. All right. And this, again, said that you were paid more than $3 million by Medicare in 2012. Is that accurate?
A. That's what it says.
Q. And this article appeared in 2014; correct?
A. I don't know. When did it -- When was it published?
Q. It says at the top April 10, 2014, State Edition. Do you see that?
A. Yes.
Q. Was there any investigation of your billing or medical record practices based on these articles?
A. No.
Q. Have you ever been investigated about your staging of cancer patients --
A. No.
Q. -- whether they were staged at higher stages versus lower stages?
A. No.
Q. The -- Have you ever been an expert witness in any lawsuit?
A. No.
Q. Have you ever been a fact witness in any lawsuit.

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A. What does that mean?
Q. Well, have you -- Have you ever been a witness in any lawsuit?
THE WITNESS: What does that mean?
Q. (By Dr. Mittler) Has any -- earlier you testified --
MR. WOOLSEY: Have you ever testified?
Q. (By Dr. Mittler) Have you ever testified as a witness in any lawsuit?
A. No.
Q. In the litigation involving Dr. Dahiya, you were never questioned by an attorney, under oath?
A. (Witness shakes head side to side.)
Q. You've never --
MR. WOOLSEY: You've got to say it out loud --
Q. (By Dr. Mittler) What is the --
MR. WOOLSEY: -- for the record.
Q. (By Dr. Mittler) Is the answer to that no?
A. No.
Q. No. Okay.
MR. WOOLSEY: Just so Debbie can get it written down. It will help out.
Q. (By Dr. Mittler) Now, do you own -- Again, do you own any other medical businesses right now?

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A. So, there was a company called Physomnia that was formed, but it's no longer a functioning entity.
THE REPORTER: How do you --
Q. (By Dr. Mittler) And what --
THE REPORTER: How do you spell that?
THE WITNESS: P-h-y-s-o-m-n-i-a.
Q. (By Dr. Mittler) And what did that business do?
A. So, we wanted all our common -- like billing and all that -- to go through that kind of entity. But it didn't work out, so we have it all ourselves.
Q. And when did that business end?
A. It's -- it's an open -- There is still a business, but there's nothing happening in there.
Q. Well, when did that business stop billing for your practice?
A. It didn't. It didn't ever bill. It just had all the common employees when we -- when we had all the previous, you know, entities.
Q. Does that business exist now?
A. No.
Q. It has no employees?
A. (Witness shakes head side to side.)
Q. When was the last time it had employees?
A. I'll have to check.

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Q. Was it a year ago?
A. (Witness shakes head side to side.)
Q. Two --
A. Maybe earlier than that.
Q. Two years ago?
A. When Dr. Jaffar left we no longer had any of those kind of employees.
Q. But you had other employees -- I mean you had other doctors still practicing; correct?
A. But we all have our own people billing and all -- collections and all that. We have it in our office.
Q. How many employees do you have working for you?
A. About 21 --
Q. And these --
A. -- 22.
Q. These are all employees of your MDPA?
A. Uh-huh.
Q. And they get a check from the MDPA?
A. Yes.
Q. Four Seasons Hospice, are you familiar with that?
A. I saw some paperwork from them, yeah.
Q. Do you have a neighbor who owns that?

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A. Who owns it?
Q. Do you know who owns it?
A. No.
Q. Do you have any financial interest in Four Seasons Hospice?
A. Financial interest?
Q. Yes.
A. I don't have any financial interests in any other except my MDPA.
Q. Did you ever have a financial interest in any hospice?
A. Never.
Q. You have been divorced how many times?
A. How is that relevant to this?
Q. My question is, you have been divorced how many times?
A. Two times.
Q. Were you ever deposed in a lawsuit -- in the divorce lawsuit, as a part of those -- either of those divorces?
A. No.
DR. MITTLER: I'll just mark one more.
MR. WOOLSEY: I'm going to hold you to that one more.
DR. MITTLER: No, I -- one more in this

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group. I'm sorry.
MR. WOOLSEY: I -- I assumed as much.
DR. MITTLER: Okay. I'm going to mark Exhibit 18. All right.
(Exhibit 18 was marked.)
Q. (By Dr. Mittler) And this is, again, another San Antonio Express-News article from November 17, 2015. Do you see that up at the top?
A. Yeah.
Q. And it says "Oncologists allege loan paperwork was forged". Do you see that?
A. Where does it say that?
Q. In blue. I'm sorry. Do you see that at the top of the -- at the top of the article?
A. (Witness nods head up and down.)
Q. Okay. I'm sorry. Do you see that at the top of the exhibit?
A. Yes.
Q. Okay. That's the headline.
And it says that -- It starts saying: Two doctors with Radiation Oncology San Antonio say in recent court filings their signatures were forged on documents used to obtain a $1 million loan for the practice. The disclosures by Drs. Jaffar and Raza have sparked an investigation by Frost Bank, which made the

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loan last year, another court document shows. Do you see that?

A. Uh-huh.

Q. Now, here's the next paragraph I want to read, and I want to ask you about it. It says, "The revelations mark the latest outgrowth in a bitter feud involving current and former officials of Radiation Oncology San Antonio, which does business as Oncology San Antonio. It has been one of the largest oncology practices in San Antonio, generating $50 million in revenue in 2012, according to a court filing. However, earlier this year it shrank its operations, shuttering the Urology & Prostate Institute, reportedly in an attempt to stabilize the practice following financial troubles." Did I read that correctly?

A. Yes.

Q. My question is, wasn't Radiology Oncology -- this says Radiation Oncology San Antonio did business as Oncology San Antonio.

A. It was a "doing business as".

Q. Well, you're still under the umbrella of Oncology San Antonio, or not?

A. But that name wasn't taken, so we had just formed that company later. It was doing business as. ROSA was doing business as Oncology San Antonio.

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Q. So, the current Oncology San Antonio is a different Oncology San Antonio?

A. Yes. That name was not taken, so we were able to get that name.

Q. And who were you practicing with at that time under one umbrella?

A. ROSA.

Q. And you were, you say, just a person, just a doctor who practiced there?

A. (Witness nods head up and down.)

Q. You weren't an employee?

A. I was not an officer.

Q. You didn't -- You didn't get a check from ROSA; correct?

A. No. I -- it was very -- The setup was very different. You know, I -- It was an S Corp or C Corp, something like that.

Q. When was the last time that you were -- that you were divorced?

A. 2015.

Q. And you asked why I'm asking these questions. Here's my point. You have a very, very busy medical practice; correct?

A. Yes.

Q. Is it fair to say -- Do you have hundreds of

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patients, thousands of patients?

A. It depends.

Q. Okay.

A. But at the time you saw Mrs. Reynolds and it was important for you to assess her stage of cancer and whether she had any of these genetic markers, there was all sorts of litigation swirling around you; isn't that -- is that a fair statement?

MR. WOOLSEY: Form.

THE WITNESS: What is that?

MR. WOOLSEY: I made an objection to the form of the question.

DR. MITTLER: You can answer.

MR. WOOLSEY: You can still answer.

DR. MITTLER: After he objects, you can answer the question.

A. I got divorced because my husband said I was married to my job. I worked all the time and I was away. He was lonely, so he ran away with somebody in his office. Does that make you happy?

Q. (By Dr. Mittler) Dr. Rao, what I'm saying -- what I'm saying is that when you're making these critical decisions on Mrs. Reynolds, you have the trauma of divorce, of practice partners and allegations of fraud and misappropriation of funds and bankruptcy

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and all sorts of litigations swirling around you; is that not true?

MR. WOOLSEY: Objection; form.

A. So, a good doctor will rise above all that.

Q. (By Dr. Mittler) But would you not agree that this puts a lot -- this put a lot of pressure on you at that point in time to concentrate on your work when all of this litigation --

A. I --

Q. -- was swirling around you?

A. Sir, we took very good care of Mrs. Reynolds. She got really good care, and I stand by it.

Q. As you've looked back on your care of Mrs. Reynolds and those decisions that you made in late November, early December of 2015, and you've read Dr. Cohen's report and you've reviewed the records and some of the literature, is there anything you'd do different about treating her now?

MR. WOOLSEY: Form.

A. I wouldn't do anything different.

Q. (By Dr. Mittler) You wouldn't do one thing different?

A. (Witness shakes head side to side.)

Q. Do you wish you had tried harder to get the --

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A. I --
Q. -- results of the ALK marker?
A. I did. I did everything appropriate to help Mrs. Reynolds.
DR. MITTLER: I need to find where my report is. I'm looking for Dr. Cohen's report. Well, let's get this into evidence first.
(Exhibit 19 was marked.)
Q. (By Dr. Mittler) I'm going to hand you what's been marked Exhibit 19, which is a copy of an article from The New England Journal of Medicine, from the December 4, 2014 issue. Do you see that?
A. Uh-huh.
Q. Have you -- Dr. Rao, have you seen this article before?
A. Yes.
Q. Did you see that Dr. Cohen cited this in his expert report in this lawsuit?
A. Yeah.
Q. Have you reviewed this -- this study?
A. Yes.
Q. And this study is titled "First-Line Crizotinib versus Chemotherapy in ALK-Positive Lung Cancer". Is that correct, the title?
A. Yes.

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Q. And the conclusion of the abstract is that "Crizotinib was superior to standard first-line pemetrexed-plus-platinum chemotherapy in patients with previously untreated advanced ALK-positive NSCLC," which stands for non-small cell lung cancer. Did I read that correctly?
A. You read that correctly.
Q. Do you agree with the findings of this study?
A. So, the findings of the study is about shortness of breathe associated with cancer. So, it was just on a few of the symptoms that -- so, it doesn't say you don't do chemotherapy.
So, the study also had an update in 2018. So, if you look at all the side effects -- Crizotinib is not Tylenol. It has lots of side effects as well.
Q. Okay. If you'll go to the page of the article 2176.
A. You want to review 2173 first?
Q. No, ma'am. I want to review 2176. Let me just hand you the highlighted --
A. It's highlighted here.
Q. Do you see it?
A. Uh-huh.
Q. Do you see the lines where it says

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"Initiating crizotinib as first-line therapy in patients whose tumors test positive for ALK rearrangements maximizes the probability that these patients will benefit from ALK-directed therapy"? Did I read that correctly.
A. Yeah.
Q. Do you agree with that statement.
A. I don't.
Q. Why not?
A. So, the -- There was an update on this study in 2018. And if you look at it, it says that -- first of all, the study design was flawed, as well. Patients who were on the chemotherapy arm were allowed to transfer to the crizotinib arm. But the -- At four years the expected survival was 56 percent for crizotinib arm versus chemotherapy was 49.6 percent.
So, it didn't really make any big difference in overall survival. This is free survival. All it was was from certain symptoms associated with lung cancer.
Q. And do you agree that this was part of the evidence used by the American Society of Clinical Oncology in their expert panel recommendations that were made on October 20, 2015, that we looked at in Exhibit 8?

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A. I haven't read that article. I have to -- I have to read it and understand it first before I answer that question.
Q. Has this article been retracted by the authors or The New England Journal of Medicine?
A. It has been updated with more information.
Q. And is it your testimony that the updated information shows that crizotinib is not the first-line treatment for non-small cell lung cancer?
A. No. It is my testimony that there are various ways to treat lung cancer, and we have to pick what is appropriate for each patient at that given point of time.
Q. And the point is that, at the point of time in which you initiated treatment in Mrs. Reynolds, the ALK genetic factor was known; correct?
A. Not to me.
Q. But it was known; correct?
A. Looking back, yes, it was known.
Q. And so, that was a critical factor to take into account in choosing the correct therapy for Mrs. Reynolds in November and December of 2015; correct?
A. I disagree.
Q. (By Dr. Mittler) And it was the correct

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factor in January of 2016, in March of 2016, in June of 2016, all the way up until June of 2017, when she was under your care; correct?

A. I --

MR. WOOLSEY: Form.

A. -- disagree.

Q. (By Dr. Mittler) And during that whole period of time, you could have obtained the results of the ALK genetic factor and you didn't; did you?

A. I disagree.

Q. Well, the term ALK, the three letters in capital, A-L-K, don't appear in your records, in other words, the records you and your nurse practitioner generated, anywhere; do they?

A. No, because we didn't know about it.

Q. Well, you didn't -- You didn't even ask about it later; correct?

A. We asked about it. We don't ask every two weeks when somebody says there was nothing -- there was no tissue to do that.

Q. But it was a critical factor when you first saw Mrs. Reynolds in terms of decision-making; do you agree with that?

A. No, I do not. Mrs. Reynolds got the best care.

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Q. Well, the standard of care would have been for you to write in your record ALK and EGFR are important factors, EGFR is insufficient, and I can't get the ALK. You didn't even make a note of that; did you?

A. So, Mrs. Reynolds got the best care she possibly -- possibly could have. She got first-line, second-line. She got good treatment. She lived a long time, and we gave her excellent care.

Q. And one of the reasons that Mrs. Reynolds lived a long time is that you didn't have the stage correct; isn't that true?

A. No, that is not true.

Q. In fact, Dr. Cohen said she was Stage IIB.

A. Dr. Cohen is not right.

(Exhibit 20 was marked.)

Q. (By Dr. Mittler) I'm going to hand you what's been marked Exhibit 20, and this is Dr. Cohen's expert report which was appended to the lawsuit, I believe, and was filled. And you sa- -- I think you've testified multiple times that you have seen this. Correct?

A. (Witness turning pages of Exhibit 20.)

Q. Can you turn to page four. Well, you have seen this report; is that correct?

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A. Yes, I have.

Q. All right. Can you turn to page four and look at the bottom of the page.

A. (Witness complies.)

Q. Do you see there's one sentence near the bottom paragraph that says, "Dr. Rao's initial note in her office suggested stage IV disease"? Do you see that?

A. Yes.

Q. And then Dr. Cohen says, "It was known that her N and M clinical staging were 0 based on a number of negative PET/CT thorax and body scans. There are no extra thoracic or nodal metastases identified on her scans. I believe her initial T Stage was T3. She should have been Staged IIB. Dr. Rao's suggestion that Mrs. Reynolds had stage IV disease was not demonstrated by any imaging testing, and she made no notation of these test results to corroborate her conclusion about disease stage."

Do you agree with Dr. Cohen's assessment?

A. I do not.

Q. Why?

A. Because scan after scan it has shown she had bilateral upper lobe tumors, and the right-sided tumor,

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the lesion never went away. In fact, it got bigger when we stopped the treatment. Dr. Conde wrote in her note that she has bilateral upper lobe breast -- I mean lung cancer. So, this is erroneous. It's -- I do not agree with that.

Q. Well, Dr. Conde wrote her note based on your notes; correct?

A. Well, Dr. Conde is her own oncologist. Why would she base her findings on my note.

Q. Well, Dr. Conde initially -- her initial notes were based on the records that she got from you; correct?

A. She -- I'm sure she looked at all the scans, and she has to come up with her own staging, sir. Why she -- I mean she -- you said that she was -- she did her own thing. She should have done her own thing all the way.

Q. Did you see that Dr. Conde termed Mrs. Reynolds' cancer "bronchoalveolar"?

A. It doesn't make any difference as to what treatments you give people.

Q. Does bronchoalveolar cancer have a different prognosis than non-small -- as a type of non-small cell?

A. It depends, again, on how old the patient is,

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what the -- what the stage was, and what treatments they got.

Q. Well, Dr. Cohen makes a point, independent of Dr. Conde, that Mrs. Reynolds had bronchoalveolar carcinoma.

A. It doesn't change anything as far as the management goes.

Q. Well, if you go over to page nine, do you see -- do you see there where the sentence -- the paragraph that starts "Finally"? Do you see that?

A. Yep.

Q. It says: Finally, I believe Mrs. Reynolds had bronchoalveolar adenocarcinoma. This type of cancer is TTF1 and CK7 positive, as was Mrs. Reynolds' tumor. Furthermore, this type of lesion is slow-growing, susceptible to lepidic growth and limited aggressivity. This tumor would explain the local tumor involvement, absence of extrathoracic metastases, lack of significant measurable response to chemotherapy, and minimal, if any, progression of tumor. Dr. Rao failed the standard of care by not seeking the pathological results of a positive ALK, TTF1, and CK7 marker.

Do you agree with that?

A. No, I do not.

Q. So, Dr. Cohen is wrong when he says that a

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bronchoalveolar adenocarcinoma with lepidic growth and limited aggressivity would give Mrs. Reynolds a better prognosis; correct?

A. It doesn't say that. TTF1 needs to be positive to say that a cancer is lung cancer.

Q. Did you --

A. So, that's basic for any lung cancer.

Q. Isn't it true that if Dr. Cohen is correct, that Mrs. Reynolds had Stage IIB adenocarcinoma, that the treatment at the time you initially saw her would have been surgery, resection of the tumor in the left upper lobe? Correct?

A. So -- No, this is not correct. There would be nobody in this town who would want to operate on a woman with bilateral upper lobe lesions that have been there for eight months. That's a joke if somebody says somebody would operate on Mrs. Reynolds at age 81 with bilateral upper lobe lesions.

Q. Well, the right -- The right upper lobe lesion was biopsied as negative for cancer; correct?

A. And so was the left upper lobe lesion biopsied at one time it was negative for cancer. That doesn't mean anything, does it?

Q. And what wasn't a joke was the fact that she did not get crizotinib as the very first treatment for

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an ALK-positive treatment; isn't that true -- cancer; isn't that true?

A. She may, you know --

MR. WOOLSEY: Form. Go ahead. I'm just objecting.

THE WITNESS: Okay.

A. So, she got therapy that was appropriate for her cancer, she lived over one and a half years on the treatments, and --

THE WITNESS: I'm trying not to say it. I won't say it.

Q. (By Dr. Mittler) What did you want to say?

A. I'm not saying it.

Q. Dr. Cohen attributed Mrs. Reynolds' neuropathy to your treatment with cisplatin; correct?

A. I don't know.

Q. And you -- Well, did you see it in his report?

A. I don't -- I haven't memorized his report, sir.

How much does Dr. Cohen get paid for this kind of thing?

MR. WOOLSEY: He's not going to answer your questions.

Q. (By Dr. Mittler) Do you know how long

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Dr. Cohen has practiced oncology/hematology in San Antonio?

A. I don't know, and I don't really care.

MR. WOOLSEY: Objection; nonresponsive.

DR. MITTLER: Let me just -- I want to go back to -- what was that first -- Exhibit 2. I want to go back to Exhibit 4, and this is the Surgical Pathology Report with your handwritten notes on it. Let me see -- is there a -- We might have to do this again. Let's look at this. Okay. Let me -- I want you to compare this with this next exhibit I'm going to mark.

THE WITNESS: Mr. Woolsey, can I please have a copy of this?

(Exhibit 21 was marked.)

Q. (By Dr. Mittler) This is Exhibit 21, which is the Surgical Pathology Report with the addendum at the bottom, which you say is not part of your records. All right.

But can you -- Can you direct your attention down just to the second page and see when this was -- do you see the addendum report there at the bottom, that says "ALK analysis (FISH)?

A. Yes.

Q. Do you see that?

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A. Yes.
Q. And FISH is the methodology they use to check the ALK genetic muta- -- mutation; correct?
A. It stands for fluorescence in situ hybridization technique.
Q. And that's a -- And that's a good technique to measure ALK; correct?
A. I don't have an opinion about whether it's a good technique or a bad technique.
Q. Well, isn't it considered in the literature the gold standard to measure ALK?
MR. WOOLSEY: Form.
A. There may be a different gold standard tomorrow, and there are better drugs than crizotinib.
Q. (By Dr. Mittler) Okay. And then -- So, at the bottom it says ALK gene arrangement detected by FISH; correct?
A. Yes.
Q. And it's electronically signed by Nancy B. Banks on 11/25/15, at 1:13 p.m.; correct?
A. That's what it says.
Q. All right. And your handwritten note says that you called -- or did an assistant call -- somebody called from your office on December 15th; correct?
A. Uh-huh.

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Q. And we don't know what year. There's not a year after that; correct?
A. I don't know.
Q. So, on some December 15th, there was a call from your office you say to the pathologist; is that right?
A. Yep.
Q. And so, all I -- all I want you to acknowledge is is that whatever 12/15 it was when -- Let me start again.
I'd like you to acknowledge that whatever December 15th it was when the call was made from your office to the pathology lab, the ALK result was, in fact, known. Do you agree to that?
A. I don't know. I can tell you many times where I have to call the pathology supervisor. You can call Dr. Rushton and talk to her. We call. And this person did something, and the other person doesn't know what it is. These are "send outs". So, I can only tell you what I know.
Q. Well, December 15th was after November 25th; correct?
A. I don't know, sir. December 15th is after November 20th. Yes, you are right.
Q. Okay. So, I'm saying that the pathology lab

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itself knew the results of the ALK determination prior to December -- to some December 15th; correct?
A. So, there's -- There is not always a congruency about when these tests come in and they put it in the system. There were doctors coming and going. I really don't know.
Q. And is it your testimony that you don't believe the standard of care required you to make a notation in Mrs. Reynolds' medical chart about the status of the ALK biomarker?
A. What I told you was I did call and tried to get all the information, and I was told there was not enough tissue to run the test. I did everything that I usually do for my patients before I start treatment. And I put my -- I promised that I would take care of her, and I took good care of her. That's all I can tell you.
Q. But you never -- You've never made a note in the chart about the ALK marker.
A. But if I didn't know what am I going to make a note about it. All I can tell you is I called.
Q. Wasn't it important to make a note about that --
A. That is important --
Q. -- prognostic marker --

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A. There are many --
Q. -- so that you can --
A. -- prognostic --
Q. -- choose treatment?
A. -- markers, sir. I've been trying to tell you. There are many prognostic markers. Why didn't she do PD-L1? Why didn't she do ROS? Why didn't she do BRAF?
Q. Why --
A. Why don't you ask her?
Q. Why didn't you do PD-L1?
A. All I can tell you is at that time things were evolving. You cannot go back five years and expect everything to be how it is now. I can only work within the confines of what pathologists and radiologists and other doctors give me to support my patients.
DR. MITTLER: I think this will be my last --
MR. WOOLSEY: Don't say it again.
DR. MITTLER: I think it will be. It depends on --
THE WITNESS: My baby has the flu, and I've been here all day.
DR. MITTLER: Okay. I understand. How

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old is your baby?
THE WITNESS: She's 12.
DR. MITTLER: Let me give you -- this is going to be the last mark -- thing I'm going to mark. I want you to look at this, Bill.
MR. WOOLSEY: Okay.
DR. MITTLER: This is the whole -- I want to mark this as Exhibit 22.
(Exhibit 22 was marked.)
THE WITNESS: I really think it's so mean to keep seeing things.
DR. MITTLER: Okay. In the interest of not adding thousands of pages, I'm giving you this part from it.
MR. WOOLSEY: What is it?
DR. MITTLER: It's the package insert on Opdivo.
MR. WOOLSEY: Okay.
DR. MITTLER: Okay?
MR. WOOLSEY: All right.
DR. MITTLER: All right.
MR. WOOLSEY: And so, this is just one little --
DR. MITTLER: Yeah. Here, I'm giving you that.

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MR. WOOLSEY: -- selected section?
DR. MITTLER: Exactly.
Q. (By Dr. Mittler) Okay. So, I'm going to give you a part I'm marking as Exhibit --
MR. WOOLSEY: Can you e-mail me the whole thing, produce it at some point?
DR. MITTLER: Yeah.
MR. WOOLSEY: I'll ask for it.
DR. MITTLER: Yeah.
Q. (By Dr. Mittler) So, I'm going to hand you what's been marked Exhibit 22, which are selected pages from the prescribing information for doctors on Opdivo. And the selected pages are 1, 2, 3, and 4. And the entire document, which we will scan and produce to your attorney, is a 56-page document. And on page one it says "Revised: 11/2016". Do you see that?
MR. WOOLSEY: Right here (pointing).
A. I see it.
Q. (By Dr. Mittler) And you prescribed Opdivo to Mrs. Reynolds; correct?
A. Yes.
Q. And this -- and the chemical name is what, nivo- -- nivolumab? Is that the correct name?
A. Nivolumab.
Q. So, it's n-i-v-o-l-u-m-a-b; correct?

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A. (Witness nods head up and down.)
Q. Otherwise known as Opdivo, O-p-d-i-v-o; correct?
A. Yes.
Q. Now, will you look -- It says "INDICATIONS AND USAGE". "OPDIVO is a programmed death receptor-1 (PD-1) blocking antibody indicated for the treatment of patients with..." Did I read that correctly?
A. Yes.
Q. And if you go down to the one, two, three -- fourth bullet, it says, "Metastatic non-small cell lung cancer and progression on or after platinum-based chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving OPDIVO." Did I read that correctly?
A. Yes, you did.
Q. Now, Mrs. Reynolds did, in fact, have the ALK genomic tumor aberration; didn't she?
A. I didn't know it.
Q. And she got Opdivo prior to having the correct therapy; isn't that true?
A. I didn't know it.
Q. But you should have known it?
MR. WOOLSEY: Form.

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A. I tried my best.
Q. (By Dr. Mittler) Why didn't you insist on getting the actual printout of the addendum or lab tests from -- the final lab tests from the Baptist Health System laboratory on the ALK and EGFR testing?
A. Dr. Miller [sic], I really loved Mrs. Reynolds. I wanted to take good care of her. I didn't do anything to harm her. I didn't -- What can I say? I -- It was something that didn't happen, and I am sorry. I did not do anything but love her and take good care of her. I hope you believe me.
DR. MITTLER: I'm going to object as nonresponsive.
Q. (By Dr. Mittler) My question is why didn't you get the final laboratory report on the ALK and EGFR testing that was available on 11/25/15, and make it part of Mrs. Reynolds' record?
A. Sir, like we've been talking all day, it just happened that I didn't get it.
Q. Well, do you --
A. I tried.
Q. Do you agree if you had gotten that record and seen that she was ALK genetic rearrangement positive, that you would have changed your therapy?
A. I wouldn't have changed my therapy. I would

have still done what I did.

Q. And that was below the standard of care; wasn't it?

A. It was not. It is standard of care.

DR. MITTLER: I have no further questions. I'll pass the witness.

THE WITNESS: Thank you.

MR. WOOLSEY: I'll reserve.

THE VIDEOGRAPHER: This concludes the deposition. We're going off the record at 3:46.

(The deposition was concluded at 3:46 p.m.)

CHANGES AND SIGNATURE

PAGE/LINE	CHANGE	REASON

I, JAYASREE RAO, M.D., have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

_____

JAYASREE RAO, M.D.

STATE OF TEXAS)
COUNTY OF _____)

Before me,_____, on this day personally appeared JAYASREE RAO, M.D., known to me or proved to me on the oath of _____ or through _____ (description of identity card or other document) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he/she executed the same for the purpose and consideration therein expressed.

Given under my hand and seal of office on this _____ day of_____, 2020.

_____

NOTARY PUBLIC IN AND FOR THE STATE OF TEXAS

My Commission Expires:

CAUSE NO. 2018-CI-13942

THELMA LOUISE REYNOLDS, § IN THE DISTRICT COURT
§
Plaintiff, §
§
vs. §
§ BEXAR COUNTY, TEXAS
§
JAYASREE RAO, M.D. and §
ONCOLOGY SAN ANTONIO §
CANCER CENTER NETWORK, §
§
Defendants. § 45TH JUDICIAL DISTRICT

****

REPORTER'S CERTIFICATE

ORAL AND VIDEOTAPED DEPOSITION
OF
JAYASREE RAO, M.D.

DECEMBER 18, 2019

****

I, Deborah A. Koole, Certified Shorthand Reporter in and for the State of Texas, hereby certify to the following:

That the witness, JAYASREE RAO, M.D., was duly sworn and that the transcript of the deposition is a true record of the testimony given by the witness;

That the deposition transcript was duly submitted on _____ to the witness or to the attorney for the witness for examination, signature, and return to me by _____ .

That a copy of this certificate was served on all parties shown herein on_____.

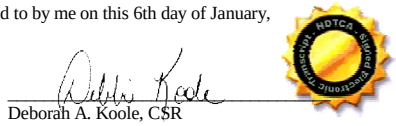
That pursuant to information given to the deposition officer at the time said testimony was taken, the following includes all parties of record and the amount of time used by each party at the time of the deposition:

Brant Mittler, Counsel for Plaintiff (4:20)
Jon Powell, Counsel for Plaintiff (0:00)
William C. Woolsey, Counsel for Defendants (0:00)

I further certify that I am neither counsel for, related to, nor employed by any of the parties in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of this action.

Further certification requirements pursuant to Rule 203 of the Texas Code of Civil Procedure will be complied with after they have occurred.

Certified to by me on this 6th day of January, 2020.



Deborah A. Koole, CSR
Texas CSR #6699, Expires 1/31/2021

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FURTHER CERTIFICATION UNDER TRCP RULE 203

The original deposition was/was not returned to the deposition officer on _____.

If returned, the attached Changes and Signature page(s) contain(s) any changes and the reasons therefor.

If returned, the original deposition was delivered to Jon Powell and Brant Mittler, Custodial Attorneys.

$ _____ is the deposition officer's charges to Plaintiff for preparing the original deposition and any copies of exhibits;

The deposition was delivered in accordance with Rule 203.3, and a copy of this certificate, served on all parties shown herein, was filed with the Clerk.

Certified to by me on this _____ day of _____, 2020.

_____
Deborah A. Koole, CSR
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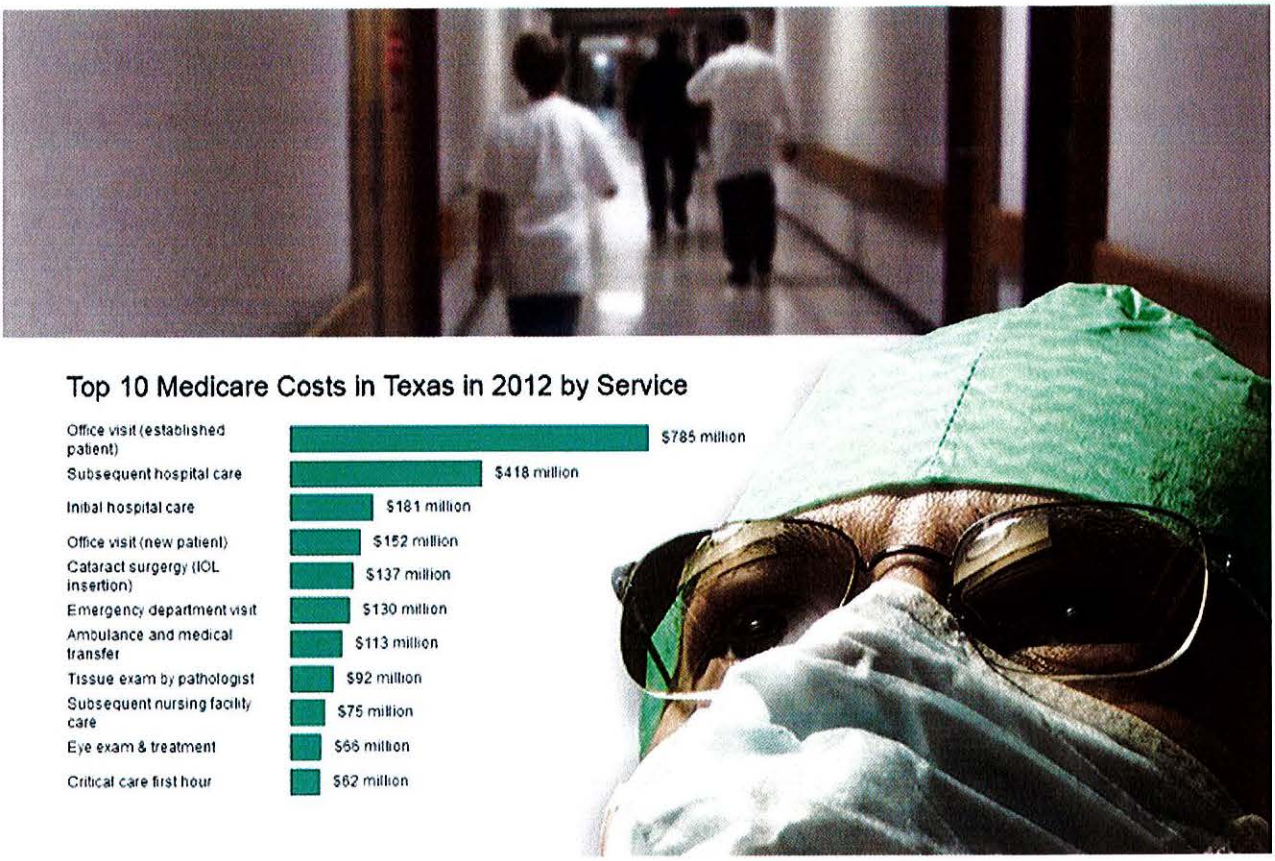
Exhibit F.

Texas Tribune article titled “Medicare Data Shines Light on Billions Paid to Texas Doctors.”

Medicare Data Shines Light on Billions Paid to Texas Doctors

Texas doctors who treat **Medicare** patients earned a combined $4.6 billion from the federal insurer of the elderly in 2012, with the state's ophthalmologists and oncologists raking in the most.

BY **BECCA AARONSON** AND **ALEXA URA** APRIL 14, 2014 6 AM



Graphic by Todd Wiseman / Carlos Paes / Becca Aaronson

EXHIBIT
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Texas doctors who treat Medicare patients earned a combined $4.6 billion from the federal insurer of the elderly in 2012, with the state's ophthalmologists and oncologists raking in the most, according to detailed data from the federal Centers for Medicare and Medicaid Services (CMS).

The massive data set, which was released last week, casts light for the first time on the money Texas doctors make for treating the state's more than 3 million Medicare beneficiaries. It lists names of physicians, the cities in which they practice, the type and number of health care services they provided and the average charges for particular services, among other details.

The data show that 342 Texas doctors were each paid more than $1 million by Medicare in 2012. The 20 doctors paid the most by Medicare that year — from a Tyler ophthalmologist who received $6.8 million to a rheumatologist from the same city who was paid $3.1 million — earned a combined $79.5 million from the federal program that year.

Physician	Specialty	City	Medicare Payments
Thomas Bochow	Ophthalmology	Tyler	$6.82 million
Reuben Elovitz	Internal Medicine	Dallas	$5.07 million
Harshivinderjit Bains	Ophthalmology	Tyler	$4.52 million
Russell Lam	Vascular Surgery	Dallas	$4.46 million
Sanjay Mehta	Radiation Oncology	Houston	$4.29 million
William Decker	Ophthalmology	Houston	$4.28 million
Alex Ehsan	Medical Oncology	Sherman	$4.22 million
Darren Kocs	Hematology/Oncology	Round Rock	$4.04 million
Matthew Benz	Ophthalmology	Houston	$4.03 million
Constantine Saadeh	Allergy/Immunology	Amarillo	$3.93 million
Tien Wong	Ophthalmology	Houston	$3.77 million
Thanh Van	Diagnostic Radiology	Houston	$3.61 million
Peter Lanasa	Radiation Oncology	Arlington	$3.52 million
Ricardo Cigarroa	Internal Medicine	Laredo	$3.48 million
Jayasree Rao	Hematology/Oncology	San Antonio	$3.33 million
James Petrikas	Radiation Oncology	Paris	$3.26 million
Jason Ysasaga	Ophthalmology	Amarillo	$3.25 million
Basel Dabas	Medical Oncology	Live Oak	$3.24 million
Antonio Aragon	Ophthalmology	Amarillo	$3.23 million
William Brelsford	Rheumatology	Tyler	$3.16 million

Created with Datawrapper

Source: Centers for Medicare and Medicaid Services, Get the data

Federal officials touted the release of the data as a step toward increased transparency in Medicare. But it was met with anxiety by health care professionals and medical associations that had fought the disclosure in court for decades until a federal court ruled last year that the information should be public.

Opponents have argued that the data could be misleading because the total payments to doctors could be interpreted as physicians' take-home pay. They argue it doesn't reveal what physicians and medical practices apply to their overhead costs, including drug treatments with hefty price tags and staff salaries.

The Texas Medical Association opposed the release of the data, President Stephen Brotherton said, arguing that it does not help patients assess their doctors and instead might leave them with questions.

Brotherton said.

The data release comes with some big caveats. For example, doctors and health care providers are differentiated in the data by their "national provider identifier" — a unique code number. But Medicare payments assigned to these identifiers may include claims for services provided by other health care professionals physicians oversee, like medical residents or assistants.

That was the case with the second-highest recipient of Medicare dollars in Texas in 2012. Dr. Reuben Elovitz, an internal medicine specialist in Dallas, was paid $5.1 million by Medicare. A spokeswoman for the doctor said that included reimbursements for services provided by several health care professionals that were filed under Elovitz's identifier while he was medical director of a Baylor University Medical Center laboratory.

Other doctors attributed their high reimbursements to costs associated with the drugs they provided to patients to treat costly medical conditions. June Cheatham, the practice administrator for Dr. Thomas Bochow, a retinal specialist in Tyler who was paid more by Medicare than any other Texas doctor in 2012, said the $6.8 million the physician received was mostly used to cover costs associated with expensive drugs he uses to treat age-related macular degeneration.

"He's not out there trying to gather Medicare dollars," she said. "He's trying to help patients retain their vision."

Indeed, more than a third of the 20 Texas doctors paid the most by Medicare in 2012 specialized in ophthalmology.

(Use this sortable table to see how much Medicare paid Texas providers by specialty in 2012. Providers who reported more than one specialty were classified by CMS by the specialty they most commonly billed under. Additionally, medical services that were provided fewer than 11 times were removed from the data altogether to protect patient confidentiality.)

Specialty	Number of Providers	Total Medicare Payments (millions)▲	Average Paid per Provider	Maximum Paid to a Provider
Internal Medicine	4,995	$602.14 M	$120,549	$5,070,967
Cardiology	1,435	$418.00 M	$291,288	$2,171,679
Ophthalmology	1,059	$372.27 M	$351,529	$6,823,316
Family Practice	5,565	$352.06 M	$63,263	$1,554,999
Diagnostic Radiology	1,923	$214.82 M	$111,709	$3,614,957
Nephrology	643	$187.11 M	$290,996	$2,930,625
Hematology/Oncology	434	$183.97 M	$423,898	$4,040,761
Emergency Medicine	2,402	$151.20 M	$62,946	$1,837,077
Orthopedic Surgery	1,365	$146.92 M	$107,631	$960,381
Dermatology	680	$141.96 M	$208,766	$2,833,000
Radiation Oncology	281	$138.18 M	$491,740	$4,287,451
Pulmonary Disease	517	$108.05 M	$208,988	$1,622,639

A spokeswoman for Dr. William Brelsford, a rheumatologist from Tyler who received $3.2 million from Medicare in 2012, said his practice accrues about $1 million in debt purchasing drugs to treat Medicare patients with arthritis before receiving reimbursements from the federal program.

Seven oncologists — doctors who treat cancer patients — were also among the 20 Texas doctors paid the most by Medicare in 2012. Oncology was a top field for doctors reporting hefty Medicare payments.

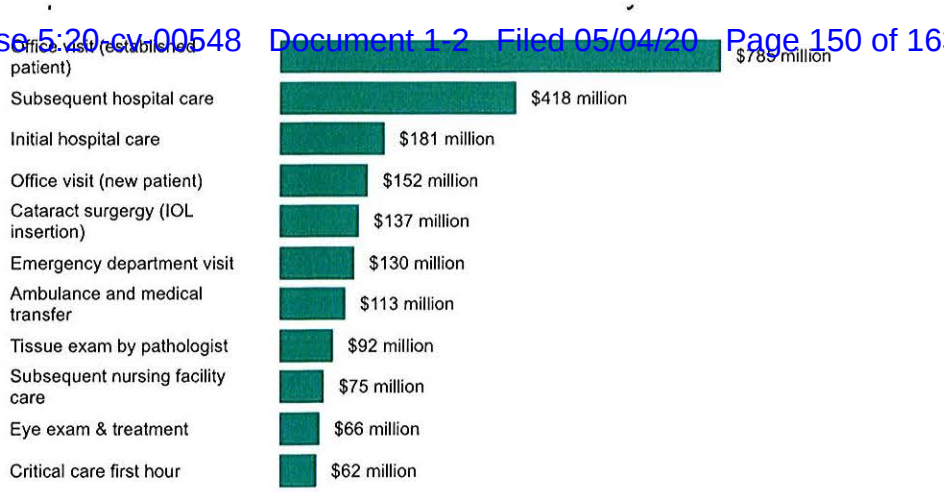
Several of the top-grossing doctors — including Drs. Alex Ehsan and Darren Kocs, who both received more than $4 million from Medicare in 2012 — both work for Texas Oncology, one of the largest cancer treatment providers in Texas with offices statewide.

“Because many cancer patients are seniors, it’s no surprise that payments for cancer treatment are significant for Medicare," said Ed Bryson, a Texas Oncology spokesman. "We support greater transparency, but the Medicare data released yesterday, without context, does not provide meaningful insight into costs per physician."

Bryson added that the data did not account for the number of patients physicians treat and the type and stage of their cancer, among other costly aspects of treating such patients.

The CMS data released also includes payments made to other service providers in Texas like hospitals, ambulance providers and nursing homes, which received hundreds of millions of dollars in Medicare payments combined in 2012 for services like hospitalization, emergency room visits and nursing care.

Texas physicians received a combined $785 million in Medicare payments in 2012 for a basic service: "office visit with an established patient."



Created with Datawrapper

Source: Centers for Medicare and Medicaid Services, Get the data

The data release could lead to increased scrutiny of physicians who are already under the microscope by federal and state watchdogs of waste and fraud in government-subsidized health services.

In a press call last week, CMS Principal Deputy Administrator Jonathan Blum said federal officials were seeking help from the public, health care researchers and reporters to identify spending "that doesn't make sense" or appears to be fraudulent.

In December, the U.S. Office of Inspector General, which investigates possible fraud and abuse for the U.S. Department of Health and Human Services, recommended that physicians who file the highest reimbursement claims to Medicare be scrutinized.

In Texas, where some providers are already on edge about what could trigger an investigation, the data could be used by the state's Office of Inspector General, which recently increased efforts to investigate possible fraud among physicians who treat poor children and disabled patients covered by Medicaid.

Stephanie Goodman, a spokeswoman for the Texas Health and Human Services Commission, said her office is still considering ways in which the data may be used, particularly when it comes to Texans who are eligible for both Medicaid and Medicare.

"It will help our researchers with an analysis of care coordination for our dual-eligible population," Goodman said in a statement. "And it gives OIG a more complete picture of a provider's operations."

This story was produced in partnership with Kaiser Health News, an editorially independent program of the Henry J. Kaiser Family Foundation, a nonprofit, nonpartisan health policy research and communication organization not affiliated with Kaiser Permanente.

Disclosure: The Texas Medical Association and the Baylor Health Care System are corporate sponsors of The Texas Tribune. Texas Oncology was a corporate sponsor of The Texas Tribune in 2012. A complete list of Texas Tribune donors and sponsors can be viewed here.

Exhibit G.

San Antonio Express-News article titled "Two S.A. doctors are on list of top Medicare payments – Correction Appended."

Two S.A. doctors are on list of top Medicare payments - Correction Appended

San Antonio Express-News

April 10, 2014 Thursday, STATE EDITION

Correction Appended

Section: A SECTION; A; Pg. 1

Length: 788 words

Byline: Peggy O'Hare

Body

For the first time, the federal government has released the names of physicians who received the biggest payments from Medicare in a single year - and two local cancer doctors are on the list.

Dr. ***Jayasree Rao*** at Oncology San Antonio and Dr. Basel Dabas at Dabas Cancer Institute each were paid more than $3 million by Medicare in 2012, according to data released Wednesday by the Centers for Medicare and Medicaid Services.

Rao attributed her billing and reimbursement figures to the high cost of new drugs for late-stage cancer treatments and to the number of geriatric patients she sees.

Rao and Dabas - who do not practice together - were among just 23 physicians in Texas and 344 nationwide to collect at least $3 million from Medicare that year, according to an Associated Press analysis of the physician data. But they hardly were the top earners.

A Florida ophthalmologist, Dr. Salomon Melgen, was paid nearly $21 million by Medicare in 2012, reaping more money from the government program that year than any other physician in the nation, the AP's analysis found. And the Texas physician who raked in more Medicare dollars than any other doctor in the state was Dr. Reuben J. Elovitz, who practices internal medicine in Dallas. He collected more than $5 million, federal data showed. *** SEE CORRECTION ***

Federal officials heralded the unprecedented release of Medicare data as a step toward transparency. The information, containing billing and payment data for 825,000 physicians nationwide, will give consumers, researchers and policymakers more insight into health care spending and physician practices, said U.S. Health and Human Services Secretary Kathleen Sebelius.

Susan Stanley

The data allow consumers to compare prices and reimbursements among physicians, medical specialties, local markets and specific types of medical procedures.

Rao, a hematologist and oncologist with offices in the Stone Oak area and in downtown San Antonio, was paid $3.3 million by the government program for services provided to 536 Medicare beneficiaries, the data showed.

While she billed Medicare more than $8.4 million for care she provided to her patients in 2012, her payment covered only about 40 percent of those costs.

Because she's also a geriatric oncologist, Rao noted she takes on a heavier caseload of older patients than do some doctors. She said many physicians do not accept Medicare patients, which might increase the number of older patients in her care.

Although Rao was paid more than $3 million by Medicare that year, she said, "it doesn't mean that's my income. It means that's what we collected. We have such huge overhead. ... Our overheads have gone up every year."

Prices of some cancer drugs have skyrocketed, and newer drugs approved to treat the most advanced cancers, such as Stage 4 illnesses, cost far more than generic medications, Rao said.

Medicare typically doesn't adjust reimbursement rates for such price increases for about six months, she said.

"For Stage 4 cancers, all the new drugs on the market are very expensive. ... So those are the ones that increase our billing," Rao said. "Billing doesn't always equate to profit.

"People are living longer (with) Stage 4 cancer with all these new drugs. ... We do what's right for the patient."

Dabas - an oncologist with offices in Live Oak, New Braunfels and Seguin - received $3.2 million from Medicare in 2012 for services he provided to 751 Medicare beneficiaries, the federal data showed. He had billed Medicare more than $14.3 million, meaning he recouped about 23 percent of those costs.

Dabas had no comment on the Medicare report Wednesday, an employee at his Live Oak office said. He did not respond to a message left by the San Antonio Express-News.

Rao has practiced in San Antonio for nine years and is one of a dozen physicians at Oncology San Antonio, the practice's website states. She specializes in treating breast cancer, genitourinary cancers and gastrointestinal cancers.

She notes that her patients have good survival rates. She also said their hospitalization rates are less than 1 percent, since her practice provides advanced hands-on care.

Rao said her office also has staff dedicated to finding financial assistance for patients unable to pay their out-of-pocket costs since Medicare covers only 80 percent of the medical bills. Rao's office raised almost $800,000 one year from foundations to help patients pay their share of bills not covered by Medicare, she said.

Susan Stanley

Dabas has practiced in San Antonio since 1997 and opened the cancer institute bearing his name in 2002, his website states.

The Associated Press contributed to this report.

To see a map showing top doctors by state receiving the most in Medicare reimbursements, go to ExpressNews.com.

Correction

SETTING IT STRAIGHT: Dr. Thomas Bochow, an ophthalmologist in Tyler, received the biggest Medicare reimbursement, more than $6.8 million, among all physicians in the state in 2012. This story had incorrect information. 20140411

Correction-Date: April 10, 2014 Thursday

Load-Date: April 11, 2014

End of Document

Susan Stanley

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User Name: Susan Stanley
Date and Time: Friday, November 15, 2019 9:11:00 AM CST
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1. *Two S.A. doctors are on list of top Medicare payments - Correction Appended*
   Client/Matter: -None-
   Search Terms: Jayasree w/3 Rao
   Search Type: Terms and Connectors
   Narrowed by:

Content Type	Narrowed by
News	-None-

Exhibit H.

San Antonio Express-News article titled "More Troubles at S.A. Oncology Practice."

BUSINESS // LOCAL BUSINESS

More troubles at S.A. oncology practice

Patrick Danner | Nov. 13, 2014

Radiation Oncology San Antonio's troubles are widening.

A new lawsuit alleges Radiation Oncology (ROSA) officials are causing the "intentional destruction of the medical practice" by, in part, failing to pay for cancer medications, supplies and equipment for ongoing patient treatment in two of its three divisions.

"Patient care is in jeopardy," alleges the suit, which was brought on behalf of the company as a shareholder derivative action by Dr. Marta Dahiya, a radiation oncologist at ROSA. The suit was filed Thursday in Bexar County District Court.

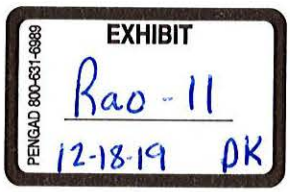
Jason Davis, ROSA's lawyer, called the allegations frivolous.

"My client will show that those reckless allegations are untrue," Davis said. "At the appropriate time, the defendants are going to seek dismissal of this suit and appropriate remedies for filing a frivolous" action.

Davis represents ROSA and its co-president, Dr. Jayasree Rao, in a lawsuit against Dahiya's husband, Dr. Rajiv Dahiya, who was removed as the practice's president and a part-owner in September. Rajiv Dahiya is alleged to have "misappropriated hundreds of thousands of dollars, if not millions" from ROSA to support his various "investment schemes and extravagant lifestyle." He remains at ROSA treating patients.

Rajiv Dahiya joined his wife as a plaintiff in the latest lawsuit, alleging Rao has made defamatory statements about his character and reputation in the medical field.

Together, the Dahiyas also are suing Scott Rickenbach, ROSA's former CFO and their financial manager. He's accused of abusing both positions "to divert and steal hundreds of thousands of dollars, if not millions, leaving the Dahiyas in financial distress." Neither Rickenbach nor his lawyer responded to a request for comment.



The lawsuit seeks unspecified financial and punitive damages against the various defendants.

Marta Dahiya alleges Rao, Jaffar and Raza have "engaged in a systematic campaign" to tank two ROSA divisions — Radiation Oncology and the Urology & Prostate Institute. The three doctors work for ROSA's other division, Medical Oncology, the suit adds.

The suit alleges the trio are "financially starving" the two divisions "through the misallocation of expenses and the creation of artificial losses." The actions have resulted in a "mass exodus of physicians and other medial providers who mostly worked" in the two divisions, it adds.

Davis, who said he hadn't read the lawsuit in detail, disputed the charges.

"Far from destroying the company, the current management has done everything they can to address the problems that were caused by the former management — including putting in their own funds," Davis said. He is a partner with Davis & Santos.

Meanwhile, the Dahiyas say they and ROSA were the victims of Rickenbach's "elaborate and sometimes desperate schemes to support his lifestyle, cover ups of misdeeds, and substantial gambling debts."

Rickenbach appears on various online betting sites as a tout — someone who charges for his betting selections on sporting events. He calls himself "The Bulldog."

In their lawsuit against Rajiv Dahiya, ROSA and Rao allege that he made unauthorized transfers totaling more than $1 million from ROSA to four companies owned or controlled by him and Rickenbach.

Rickenbach, in a sworn affidavit attached with the lawsuit, outlined various alleged misdeeds by Rajiv Dahiya. Among them: That the doctor used a ROSA-issued black American Express card for non-company expenses, which sometimes exceeded $100,000 a month. ROSA and Rao's lawsuit was filed in September.

But the Dahiyas, in their suit, claim that Rickenbach was using their money and ROSA's funds "to hide and cover up losses and shortfalls in bank accounts controlled by Rickenbach but in the name of the Dahiyas as well as ROSA."

"As the facts unfold, it will be clear that the allegations raised against Dr. (Rajiv) Dahiya were actually instigated and implemented by Rickenbach," said Gay Gueringer, the Dahiyas' lawyer. She is a partner in the firm Richie & Gueringer.

Exhibit I.

San Antonio Express-News Article titled "Oncologists allege paperwork was forged."

Oncologists allege loan paperwork was forged

San Antonio Express-News

November 17, 2015 Tuesday, STATE EDITION

Section: A SECTION; A; Pg. 1

Length: 849 words

Byline: Patrick Danner

Body

Two doctors with Radiation Oncology San Antonio say in recent court filings their signatures were forged on documents used to obtain a $1 million loan for the practice.

The disclosures by Dr. Zulfaqqar Jaffar and Dr. Syed Raza have sparked an investigation by Frost Bank, which made the loan last year, another court document shows.

The revelations mark the latest outgrowth in a bitter feud involving current and former officials of Radiation Oncology San Antonio, which does business as Oncology San Antonio. It has been one of the largest oncology practices in San Antonio, generating $50 million in revenue in 2012, according to a court filing. However, earlier this year it shrank its operations, shuttering the Urology & Prostate Institute, reportedly in an attempt to stabilize the practice following financial troubles.

Litigation erupted in state District Court last year but landed in U.S. Bankruptcy Court in San Antonio two months ago following the Chapter 7 liquidation filing of Scott Rickenbach, who was Radiation Oncology's chief financial officer at the time Frost Bank made its loan. He was terminated in September 2014.

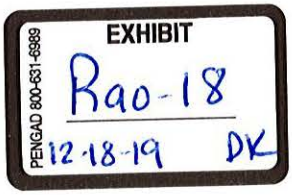
Rickenbach was a "key figure" in negotiating the loan and was "responsible for obtaining certain signatures on some of the loan documents," including personal guarantee agreements to be signed by Jaffar and Raza, Frost Bank states in an Oct. 12 court filing.

Radiation Oncology defaulted on the note in May - owing all but about $10,500 of the $1 million, Frost Bank alleges in an Aug. 21 lawsuit seeking to get the loan paid. Jaffar and Raza each responded in separate court filings that Frost Bank's claims were "barred" because of the forgeries.

William Kingman, an attorney or Jaffar and Raza, said his clients don't know who signed their names on the loan documents.

"They were unaware of the guarantees until well after the fact," Kingman said.

Susan Stanley



In its court filing in the Rickenbach case, Frost Bank asked the court for more time to investigate the forgery contentions to determine if it may have have a potential claim in the bankruptcy. The court gave the bank until Dec. 21.

Rickenbach and his bankruptcy lawyer, Michael O'Connor, didn't respond to a request for comment. Rickenbach and wife listed assets of $500,000 and liabilities of about $769,000 in the bankruptcy.

Robert Barrows, Frost Bank's attorney, also didn't return a phone call.

Frost Bank also named in its lawsuit former Radiation Oncology President Dr. Rajiv Dahiya and his wife, Dr. Marta Dahiya, who was a shareholder. Their names were on the loan documents, as well. The couple, however, were dropped from the suit on Thursday - two days after they filed for Chapter 7 bankruptcy. The pair has yet to file a list of their assets and liabilities.

The Dahiyas' bankruptcy lawyer, Eric Taube, didn't respond to a request for comment.

In September 2014, Radiation Oncology and its co-president, Dr. ***Jayasree Rao***, sued Dr. Rajiv Dahiya alleging he "misappropriated hundreds of thousands of dollars, if not millions" from the practice to support his "investment schemes and extravagant lifestyle." Dahiya is accused of having made unauthorized transfers - unrelated to the practice - totaling more than $1 million to four companies owned or controlled by him and Rickenbach. The plaintiffs also allege that Dahiya is responsible for the practice's losses. Dahiya has disputed the allegations.

Less than two months later, Marta Dahiya filed a shareholder derivative action against Rao , Jaffar, Raza and Rickenbach alleging the "intentional destruction" of Radiation Oncology. In an amended compliant, Marta Dahiya alleged Rao was successful in "sinking" the practice's Urology division. A lawyer for Radiation Oncology previously called the allegations "reckless."

Marta Dahiya also alleged Rickenbach, whom she described as her and her husband's "trusted financial manager," abused his position to "divert and steal hundreds of thousands of dollars, if not millions, leaving the Dahiyas in financial distress." Rickenbach, for his part, accused Rajiv Dahiya of various wrongdoing.

The disputes have "gotten uglier and more acrimonious everyday," Ronald Johnson, a lawyer for Radiation Oncology, told U.S. Bankruptcy Judge Craig Gargotta during a court hearing Friday. "The parties in this litigation have spent in excess of $300,000 (in litigation costs), and there's nothing but blood and tears to show for it to date. I think whatever happens will be a very Pyrrhic victory."

With the Dahiyas' bankruptcy filing, any litigation claims they have are now owned by the Chapter 7 trustee. It will be up to the trustee to decide whether he wants to pursue those claims.

Meanwhile, Amegy Bank last month entered into an agreed judgment of $520,000 with Radiation Oncology and the Dahiyas related to four business loans the practice defaulted on. The Dahiyas had guaranteed the loans, Amegy said in lawsuit filed in July.

Separately, Amegy in August entered into an agreed judgment for about $250,000 with Rajiv Dahiya after it alleged he failed to pay back two loans.

Susan Stanley

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1. *Oncologists allege loan paperwork was forged*
Client/Matter: -None-
Search Terms: Jayasree w/3 Rao
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